Comagine Health

Nevada Telehealth Summary

2021

Reimagining health care, together.

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Nevada Telehealth Summary

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Introduction

While telehealth service delivery for Medicare beneficiaries is homogeneous across the nation, state Medicaid agencies differ widely in services that are covered, reimbursement, consent and more. For purposes of this summary report for the state of Nevada, telehealth is defined as synchronous telecommunication using both audio and video for delivery of health care services and is confined to the ~ 110 Category 1 and 2 (permanent) codes listed on the Centers for Medicaid & Medicaid Services (CMS) List of Telehealth Services as of Nov 2021.

There are additional state-specific variances in coverage of remote physiologic monitoring, audio-only telehealth, and other provisions around telehealth. This report seeks to highlight some of those differences, including any best practices, recommendations, or suggestions to help inform post-pandemic remote service delivery in Nevada.

Comagine Health began research efforts at the Center for Connected Health Policy (CCHP) website for the initial source for Nevada-specific telehealth information and then researched the statutes, provider manuals, etc. as they were available, including the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath".

Best Practices

After reviewing many states' telehealth policies, several telehealth best practices emerged for Medicaid agencies and lawmakers.

- **Simplify consent for telehealth services.** Nevada is one of the few states that does not require consent.
- **Create a one-stop resource with all telehealth-related information.** Researching to find all references and regulations is time-consuming. If the information is not readily available and clear for telehealth providers, there is the risk for poor quality telehealth service delivery. Nevada does not have this type of resource.
- **Clearly state that any services delivered by telehealth must comply with all components and procedural definitions** for the CPT/HCPCs code that is billed. This is seemingly obvious but important point in several places but can be a good reminder.
- **Reinforce that telehealth services must be clinically appropriate** (again, seemingly obvious).
- **Clearly define teledentistry, school-based telehealth** and other uses of telehealth beyond primary care.
- **Reimburse for remote physiologic monitoring (RPM)** but follow Medicare guidance.
- **Allow audio-only options** to reduce health inequity especially for behavioral health.

Telehealth Definition

Nevada Medicaid's definition: "Telehealth is the use of a telecommunications system instead of an in-person recipient encounter for professional consultations, office visits, office psychiatry services and a limited number of other medical services." Telehealth Billing Instructions.

Billing Specifics

In Nevada "The provider at the distant site must use Place of Service (POS) Code 02 when billing for services provided via telehealth." Telehealth Billing Instructions. POS 02 Telehealth Provided Other than in Patient's Home (updated by CMS in October 2021).

Consent

Medicare consent is straightforward and requires beneficiary consent — verbal or written — for telehealth and other virtual services that includes notification of any applicable cost-sharing, including potential deductible and coinsurance amounts. Consent must be documented in the patient's medical record. This aligns with cost transparency and helps reinforce that "Telehealth services substitute for an in-person encounter."[1] For Nevada we did not find regulations, statutes or other guidance regarding consent, but did find this consent form from the Nevada Legislature website.

Suggestions for inclusion in consent if Nevada decides to require consent:

- Include the Medicare consent requirements above.
- Advise patients as part of consent that telehealth visits are just like in-person visits only they are conducted by audio and video with the patient in one location and the provider in a different location. All the requirements for the telehealth visit are the same, although telehealth makes physical exams and vital signs more challenging.
- Provide guidance to telehealth providers on frequency of consent (e.g., prior to each visit or annually)
- Clarify that the care team or nonclinical staff with appropriate training may discuss, obtain, and document consent in the medical record

In-Person Visit Requirements

Some states clearly state that an in-person visit is required prior to delivering telehealth services. For other states (e.g., CA), there is nothing stated, and in CO and TX it is clearly stated that an in-person visit is not required prior to a telehealth visit. For Nevada the only information we found pertains to the requirement for an in-person visit when providing telehealth ESRD services. Medicaid Services Manual Changes Chapter 3400-Telehealth Services

Distant & Originating Site

Distant site (where the provider is). We did not find any limitations on where a distant site must be when delivering telehealth services to a patient at an originating site. "Effective December 1, 2015, telehealth may be used by any Nevada Medicaid and Nevada Check Up provider working within their scope of practice to provide services that can be appropriately provided via telehealth." Telehealth Billing Instructions. This suggests that patients may receive services from providers located outside of Nevada assuming all required training, licensing,

[1] CMS Telehealth Booklet. March 2020. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

and privileging has been completed – please confirm with Nevada Medicaid if this impacts your practice. We did not find information on whether a provider may use their home as a distant site.

Originating site (where the patient is). Most states do not limit the originating site and include the patient's home. Nevada has the following specifics.

"The originating site must be located within the State of Nevada and is the location where the recipient is.", including the patient's home. Telehealth Resource Guide.

"If the originating site is enrolled as a Nevada Medicaid provider, they may bill Healthcare Common Procedure Coding System (HCPCS) code Q3014 (Telehealth originating site facility fee)." Telehealth Billing Instructions ~ check the document for full details, but NV considers FQHCs and RHCs as eligible sites.

"Facilities that are eligible for encounter reimbursement (e.g., Indian Health (IH) programs, Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs)) may bill for an encounter in lieu of an originating site facility fee, if the distant site is for ancillary services (i.e., consult with specialist). If, for example, the originating site and distant site are two different encounter sites, the originating encounter site must bill the telehealth originating HCFA Common Procedural Coding System (HCPCS) code and the distant encounter site may bill the encounter code." Medicaid Services Manual Changes Chapter 3400-Telehealth Services

Continuity and Coordination of Care

Some but not all states require that distant site providers ensure continuity by providing the primary care provider with notes from the telehealth visit. Nevada does not have verbiage or requirements to ensure continuity and coordination of care when telehealth services are delivered.

Example from Idaho Medicaid: "Rendering providers must provide timely coordination of services, within three business days, with the participant's primary care provider. The PCP should be provided in written or electronic format a summary of the visit, prescriptions and DME ordered, if applicable, and any other pertinent information from the visit."[2] The only recommendation is to clearly list that sharing the assessment and plan of care is required rather than just "summary of the visit".

Federally Qualified Health Centers (FQHCs) & Rural Health Clinics (RHCs)

Most if not all state Medicaid agencies reimburse FQHCs and RHCs as distant sites for delivering telehealth but pay according to the prospective payment system (PPS) or all-inclusive rate (AIR), respectively. We direct readers to Comagine Health's Telehealth and Virtual Services: A Guide for FQHCs and RHCs for additional details, including specifics for Nevada.

[2] Idaho Medicaid Provider Handbook. General Information and Requirements for Providers. Updated June 9, 2021. https://www.idmedicaid.com/General%20Information/General%20Information%20and%20Requirements%20for%20Providers.pdf

Audio-Only

Most state Medicaid agencies do not reimburse for audio-only telehealth (with exceptions during the public health emergency declaration (PHE)). Based on available information, Nevada does not allow audio-only telehealth.

Asynchronous Telehealth Services

In Nevada "Asynchronous telehealth services, also known as Store-and-Forward, are defined as the transmission of a patient's medical information from an originating site to the health care provider distant site without the presence of the recipient. The DHCFP reimburses for services delivered via asynchronous telehealth, however, these services are not eligible for originating site facility fees." Medicaid Services Manual Changes Chapter 3400-Telehealth Services. It is not clear for which asynchronous telehealth services Nevada Medicaid reimburses.

Coverage Parity

Most states offer a select set of services for telehealth service delivery while others cover all 109 of the Category 1 and 2 telehealth codes. Nevada Medicaid states that "Services provided via telehealth have parity with in-person health care services." Medicaid Services Manual Changes Chapter 3400-Telehealth Services

Payment Parity (reimbursement equal to in-person visit)

Same as above: Nevada Medicaid states that "Services provided via telehealth have parity with in-person health care services." Medicaid Services Manual Changes Chapter 3400-Telehealth Services

Telebehavioral Health & Substance Use Disorder Services

We did not find these telehealth services separately addressed in the Nevada Medicaid documents. However, because Nevada has payment and coverage parity these services should be covered when delivered by telehealth.

Telehealth Platforms

Even if it is not explicitly stated (it usually is), best practice dictates having a HIPAA-compliant platform. For Nevada, we did not find mention of using a HIPAA-compliant platform outside of Nevada Medicaid documents that are specific to the PHE.

Documentation

Documentation for telehealth visits requirements is mostly the same as for in-person visits but should also include that the visit was conducted by telehealth, patient consent, locations of the originating and distant sites, start and stop times, names and roles of all individuals participating or observing at the originating and distant sites, back-up and emergency plan if the technology fails or patient requires emergency medical services (EMS),

and if treating a minor, documentation that parent/guardian was present. Most states require documentation that the visit was conducted by telehealth and often clarify that both telehealth and in-person visits and accompanying documentation must comply with all components and procedural definitions for the CPT or HCPCS code that is billed. For Nevada, we did not find details on required documentation for telehealth visits.

Cross-State Licensure

Most state Medicaid agencies required licensure within the Medicaid beneficiary's state to provide telehealth services, and several also include the requirement to be a Medicaid-enrolled provider. In Nevada providers must be licensed in the state of Nevada to provide telehealth but do not need to live in the state RS 629.515. Additionally, Nevada is a member of the Interstate Medical Licensure Compact and the Psychology Interjurisdictional Compact (PSYPACT) Psychosocial Rehabilitation (PSR) services.

School-Based Telehealth

While we did not find information from Nevada Medicaid regarding school-based telehealth, please see this Nevada School-Based Health Center Toolkit.

Teledentistry

There are no teledentistry regulations in Nevada nor does Nevada Medicaid define teledentistry, according to MouthWatch Teledentistry Regulations in Your State . The Nevada State Board of Dental Examiners notes from April 2, 2020 reiterate that in the Board's July 2019 public meeting, the Board "…passed a motion finding that telehealth is within the scope of NRS 631.215, which defines the practice of dentistry in the State of Nevada. The Board also voted to create a regulation to address and define telehealth as it relates to the practice of dentistry in the State of Nevada. While such a regulation has yet to be created and adopted, the Board has already concluded that practitioners may practice in teledentistry."

Remote Physiologic (or patient) Monitoring (RPM)

RPM is the one virtual service that has the greatest potential to reduce ED visits, admissions, and readmissions. RPM is a great addition to self-management support for patients, and many primary care clinics often include and bill for these services as part of Chronic and Principal Care Management. Nevada Medicaid does not reimburse for the

There are at least three distinct versions of RPM.

1. RPM as defined by Medicare, includes five billing codes (see Remote Physiologic Monitoring (RPM)) none of which are reimbursed by Nevada Medicaid.
2. Remote patient monitoring that may or may not be "physiologic" can be a great adjunct for chronic disease and other self-management and may include regular check-ins, reminders, diet logs and so much more. With the explosion of patient health apps, the possibilities continue to expand.
3. Medicare reimburses for other RPM services (e.g., self-measured blood pressure monitoring and continuous glucose monitoring (CGM), and ambulatory blood pressure monitoring) that don't

technically fall under Medicare's RPM definition from 1 above. Nevada Medicaid reimburses for the CGM codes in the table below.

Service Descriptions, Codes and Prices for Continuous Glucose Monitoring (CGM)

The first amount in parenthesis is the Medicare amount and the second amount is from the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath".

Service Description	Code – Price ($Medicare/$NV Medicaid)
Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording (check additional reporting requirements in an official CPT codebook).	95249($59/$48)
Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; physician or other qualified health care professional (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	95250($157/$141)
Ambulatory CGM of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; interpretation and report.	95251($36/$38)
The national payment amount for the non-facility price from the Physician Fee Schedule Search as of Nov 1, 2021 is rounded to the nearest dollar. Do not rely on the pricing information in this table; have your biller/coder double-check.	

Interprofessional Consultations (e-Consults)

None of the six codes for conducting e-consults are listed on the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath", suggesting that these services are not covered by Nevada Medicaid. However, if you're not an FQHC or RHC and have Medicare beneficiaries, this is a great option for consults.

Resource: Interprofessional Consultation: A Person-Centered Referral Option – a blog summary with additional resources from the Southwest Telehealth Resource Center

Nevada Medicaid Telehealth Resources

- Telehealth Billing Instructions
- Telehealth Resource Guide
- Medicaid Services Manual Changes Chapter 3400-Telehealth Services

Appendix

Nevada Telehealth Services and Codes

The table below includes all 109 Category 1 and 2 telehealth codes and the 58 Category 3 codes (available through December 31, 2023). The interim codes are not included. Descriptions of the four categories of codes are below. These are the same codes that are found on the full CMS List of Telehealth Services. In the table, all telehealth services and codes are grouped and include brief descriptions and the CMS prices (national payment amount for the non-facility price or the facility price if there is no non-facility price). The second set of parentheses include the reimbursement listed in the Nevada Department of Health and Human Services Division of Health Care Financing and Policy fee schedule for "Provider Type 20 Physician, MD, Osteopath". If a code was not found on this list, the payment amount is entered as a question mark (?).

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services. Noted in black font in the table below.

Category 2: Services that do not fall into the description of the Category 1 codes but that may provide demonstrated benefit to patients. Noted in black font in the table below.

Category 3: This category was added in the Calendar Year 2021 Physician Fee Schedule Final Rule. These services are added on a temporary basis following the end of the PHE and will likely provide clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria. Category 3 services need to meet the criteria under Category 1 or 2 to be permanently added to the Medicare telehealth services list. They will remain on the list of telehealth services through December 31, 2023. Noted in blue font in the table below.

Interim Services: As of November 2021, there are 135 services that are added on an interim basis. These services may only be delivered by telehealth through the end of the PHE.

See your CPT® Professional codebook for full descriptions and additional requirements. None of the content herein can be construed as billing advice.

Contents of Table

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)	
Evaluation & Management (E/M) Visits - Outpatient		
Office or other outpatient visits for new patients (99202-99205) and established patients (99211-99215).	99202($74/$48) 99203($114/$70) 99204($170/$108) 99205($224/$134)	99211($23/$13) 99212($57/$28) 99213($92/$47) 99214($131/$70) 99215($183/$94)
Level 1 (99334) or Level 2 (99335) established patient domiciliary, rest home, or custodial care visit Level 1 (99347) or Level 2 (99348) established patient home visit The CY 2021 PFS FR (p. 84505) states that "the patient's home cannot serve as an originating site" and that "because the home is not generally a permissible telehealth originating site, these services could be billed when furnished as telehealth services only for treatment of a SUD or co-occurring mental health disorder," citing the SUPPORT Act.		99334($60/$39) 99335($96/$61) 99347($55/$36) 99348($84/$54)
Home visit for the E/M of an established patient, requiring specific: 99349 - usually, the presenting problem(s) are moderate to high severity. Typically, **40 min are spent face-to-face** with the patient and/or family, 99350 - usually, the presenting problem(s) are of **moderate to high severity**. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, **60 min are spent face-to-face** with the patient and/or family.		99349($129/$82) 99350($179/$115)
Prolonged E/M or psychotherapy services in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (99354) and each additional 30 min (99355)		99354($129/$65) 99355($96/$63)
Prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact		G0513($66/?) G0514($66/?)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
beyond the usual service; first 30 min (G0513) and each additional 30 min (G0514) CY 2018 PFS FR p. 53079	
The Consolidated Appropriations Act, 2021 - passed Dec. 21, 2020 - delays the permanent addition of HCPS code G2211 until 2024.	G2211
Prolonged office or other outpatient E/Ms 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 min – add-on code for 99205 and 99215	G2212($34/?)
Hospital, Nursing Facility & Critical Care Consult Services	
Telehealth consultations, emergency department or initial inpatient	G0425($101/?) G0426($136/?) G0427($200/?)
Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])	99217($72/$47)
Subsequent observation care, per day, for the E/M of a patient, with required components: 99224 - usually, the patient is stable, recovering, or improving. Typically, 15 min are spent at the bedside and on the patient's hospital floor or unit, 99225 - usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 min are spent at the bedside and on the patient's hospital floor or unit, 99226 - usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 min are spent at the bedside and on the patient's hospital floor or unit.	99224($39/$26) 99225($72/$47) 99226($103/$67)
Subsequent hospital care services, with the limitation of 1 telehealth visit every three days	99231($38/$25) 99232($72/$46) 99233($103/$67)
Hospital discharge day management; 99238 - 30 min or less, 99239 - more than 30 min	99238($72/$47) 99239($106/$69)
Emergency department visit for the E/M of a patient, requiring specific components: 99281 - usually, the presenting problem(s) are **self-limited or minor**, 99282 - usually, the presenting problem(s) are of **low to moderate severity**, 99283 - usually, the presenting problem(s) are of **moderate severity**, 99284 - usually, the presenting problem(s) are of **high severity, and require urgent evaluation** by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function, 99285 - usually, the presenting problem(s) are of **high severity and pose an immediate significant threat** to life or physiologic function.	99281($22/$14) 99282($43/$27) 99283($73/$40) 99284($124/$76) 99285($181/$111)
Critical care, E/M of the critically ill or critically injured patient; first 30-74 min; 99292 - each additional 30 min	99291($221/$178) 99292($124/$79)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient E/M service) (99356) and each additional 30 min (list separately in addition to code for prolonged service (99357)	99356($91/$59) 99357($92/$59)
Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy	G0459($43/?)
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307($44/$29) 99308($69/$45) 99309($91/$59) 99310($135/$87)
Nursing facility discharge day management; 30 min or less; 99316 - more than 30 min	99315($72/$47) 99316($105/$68)
Level 1 (99334) or Level 2 (99335) established patient domiciliary, rest home, or custodial care visit Level 1 (99347) or Level 2 (99348) established patient home visit The CY 2021 PFS FR (p. 84505) states that "the patient's home cannot serve as an originating site" and that "because the home is not generally a permissible telehealth originating site, these services could be billed when furnished as telehealth services only for treatment of a SUD or co-occurring mental health disorder," citing the SUPPORT Act.	99334($60/$39) 99335($96/$61) 99347($55/$36) 99348($84/$54)
Domiciliary or rest home visit for the E/M of an established patient, requiring specific components: 99336 - usually, the presenting problem(s) are of moderate to high severity. Typically, 40 min are spent with the patient and/or family or caregiver, 99337 - usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 min are spent with the patient and/or family or caregiver.	99336($135/$86) 99337($194/$125)
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307($44/$29) 99308($69/$45) 99309($91/$59) 99310($135/$87)
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or skilled nursing facilities	G0406($38/?) G0407($72/?) G0408($103/?)
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 min communicating with the patient and providers via telehealth (G0508), and subsequent, physicians typically spend 50 min communicating with the patient and providers via telehealth (G0509)	G0508($210/?) G0509($191/?)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Added in 2017 to "…report an intensive telehealth consultation service, initial or subsequent, for the critically ill patient, for example, a stroke patient, under the circumstance when a qualified health care professional has in-person responsibility for the patient, but the patient benefits from additional services from a distant-site consultant specially trained in furnishing critical care services." CY 2017 PFS FR p. 80198	
Subsequent inpatient neonatal critical care, per day, for the E/M of a **critically ill neonate**, 28 days of age or younger	99469($396/$255)
Subsequent inpatient pediatric critical care, per day, for the E/M of a **critically ill infant or young child**, 99472 - 29 days through 24 months of age, 99476 - 2 through 5 years of age	99472($403/$259) 99476($344/225)
Subsequent intensive care, per day, for the E/M of the recovering 99478 - very low birth weight infant (present body weight less than 1500 grams), 99479 - low birth weight infant (present body weight of 1500-2500 grams), 99480 - infant (present body weight of 2501-5000 grams)	99478($136/$89) 99479($124/$80) 99480($119/$77)
Post-Discharge Services	
Transitional care management (TCM)services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) (99495) and with high medical decision complexity (face-to-face visit within seven days of discharge) (99496) If you are the surgeon or provider who performed a procedure on the TCM patient, you cannot bill TCM within the procedure's global period. Conversely, if you are the PCP or hospitalist who discharged the TCM patient, you can bill within 30 days of discharge.	99495($208/$106) 99496($282/$151)
Behavioral and Mental Health **Must-Have Resource: Medicare Mental Health. CMS. Updated June 2021.**	
Individual psychotherapy	90832($78/$41) 90833($71/$42)) 90834($103/$55) 90836($90/$$53) 90837($152/$82) 90838($119/$71)
Psychotherapy for crisis: 90839 - first 60 min, 90840 - each additional 30 min	90839($145/$86) 90840($69/$41)
Psychoanalysis	90845($98/$59)
Family psychotherapy (without the patient present)	90846($99/?)
Family psychotherapy (conjoint psychotherapy) (with patient present)	90847($103/$68)
Group psychotherapy (other than of a multiple-family group)	90853($28/$17)
Psychiatric diagnostic interview examination	90791($181/$86) 90792($202/$92)
Interactive complexity add-on (for psychotherapy codes). See Commonly Used CPT Codes section in Medicare Mental Health. CMS. Updated June 2021.	90785($15/$9)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Neurobehavioral status examination (clinical assessment of thinking, reasoning and judgement) – includes face-to-face time and interpreting test results and preparing the report, first hour (96116) and each additional hour (96121)	96116($97/$61) 96121($82/?)
Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour. 96131 - each additional hour	96130($121/?) 96131($91/?)
Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour. 96133 - each additional hour	96132($133/?) 96133($104/?)
Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 min. 96137 - each additional 30 min	96136($47/$30) 96137($42/$28)
Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 min. 96139 - each additional 30 min	96138($37/$25) 96139($37/$28)
96156 Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making) 96158 Health behavior intervention (HBI), individual, face-to-face; initial 30 min 96159 - each additional 15 min 96164 HBI, group (2 or more patients), face-to-face; initial 30 min, 96165 - each additional 15 min 96167 HBI, family (with the patient present), face-to-face; initial 30 min, 96168 - each additional 15 min	96156($97/$63) 96158($67/$43) 96159($23/$15) 96164($10/$6) 96165($5/$3) 96167($71/$46) 96168($25/$16)
Health Risk Assessment: administer questionnaire to help identify a specific health risk to a patient (96160) or a patient's caregiver (96161), analyzes the results, assigns a score, and documents the findings.	96160($3/$3) 96161($3/$3)
Substance Use Disorder (in addition to Behavioral/Mental Health above)	
G2086: Office-based treatment for a substance use disorder (SUD), including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 min in the first calendar month. G2087: Office-based treatment for (SUD), including care coordination, individual therapy and group therapy and counseling; at least 60 min in a subsequent calendar month. G2088: Office-based treatment for (SUD), including care coordination, individual therapy and group therapy and counseling; each additional 30 min beyond the first 120 min Note that the facility price for the three codes is lower: $287, $281, $34, respectively. For full discussion of these codes and services see Bundled Payments Under the PFS for	G2086($395/?) G2087($351/?) G2088($67/?)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Substance Use Disorders (HCPCS Codes G2086, G2087, and G2088) in the CY 2021 PFS FR (pp. 84642-3)	
Chronic Kidney Disease (CKD) and End-Stage Renal Disease (ESRD) **None of the reimbursement amounts for these codes are listed on the NV Medicaid fee schedule "Provider Type 20 Physician, MD, Osteopath".**	
Individual and group kidney disease education services Coverage of Kidney Disease Patient Education Services. CMS. Updated Jn 2013.	G0420($114) G0421($27)
ESRD-related services included in the monthly capitation payment ESRD billing can be complex and is beyond the scope of this guide. There is either no record found or no price on the Physician Fee Schedule for the seven Category 1 and 2 codes (black font) listed on the right, although they are on the CMS list of telehealth services.	90951($1,199) 90952 90953 90954 90955 90956 90957 90958 90959 90960 90961 90962
ESRD-related services for home dialysis per full month, for patients < 2 years of age (90963), 2-11 years of age (90964), and 12-19 years of age (90965) to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963($620) 90964($532) 90965($512)
ESRD-related services for home dialysis per full month, for patients ≥ 20 years of age	90966($300)
ESRD-related services for dialysis less than a full month of service, per day; for patients < 2 years of age (90967), 2-11 years of age (90968), 12-19 years of age (90969), and ≥ 20 years of age (90970)	90967($18) 90968($18) 90969($17) 90970($10)
Patient Self-Management, Education, Wellness and Lifestyle Changes	
Individual and group medical nutrition therapy	G0270($32/?) 97802($38/?) 97803($32/?) 97804($17/?)
Individual and group diabetes self-management training (DSMT) services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training • American Diabetes Association's 2020 Standards of Medical Care in Diabetes states that "all people with diabetes should participate in diabetes self-management education" and "all individuals with diabetes should be referred for individualized MNT." • Medicare Reimbursement Guidelines for DSMT. Centers for Disease Control and Prevention's (CDC). Accessed June 2021. • Medicare Preventive Services - Diabetes Self-Management Training. CMS. Accessed June 2021.	G0108($56/?) G0109($16/?)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Smoking cessation services • Tobacco Use Prevention and Cessation Counseling. American Academy of Family Physicians. 2017.	99406($16/$11) 99407($29/$21)
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services • Screening, Brief Intervention, & Referral to Treatment (SBIRT) Services. CMS. Updated April 2016.	G0396($36/?) G0397($68/?)
Annual alcohol misuse screening, 15 min (G0442) and brief face-to-face behavioral counseling for alcohol misuse, 15 min (G0444)	G0442($19/?) G0443($27/?)
Annual depression screening, 15 min • Screening for Depression in Adults. CMS. Updated March 2012.	G0444($19/?)
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 min • Screening for Sexually Transmitted Infections (STIs) and High Intensity Behavioral Counseling (HIBC) to Prevent STIs. CMS. Updated May 2012.	G0445($28/?)
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 min • Intensive Behavioral Therapy (IBT) for Cardiovascular Disease (CVD). CMS. Updated March 2021.	G0446($27/?)
Face-to-face behavioral counseling for obesity, 15 min	G0447($27/?)
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit (G0438) and subsequent visit (G0439) • Medicare Annual Wellness Visits. CMS. Accessed June 2021.	G0438($169/?) G0439($134/?)
Advance Care Planning, 30 min (99497) and each additional 30 min (99498) • Advance Care Planning Fact Sheet. CMS. Updated 2020.	99497($86/?) 99498($74/?)
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making • Medicare Coverage of Screening for Lung Cancer with Low Dose Computed Tomography (LDCT). CMS. Updated June 2017. • For a decision tree and lung cancer screening guidelines across organizations, see Lung Cancer Screening Guidelines Implementation in Primary Care: A Call to Action. Ann Fam Med. 2020.	G0296($29/?)
Comprehensive assessment of and care planning for patients requiring chronic care management • Chronic Care Management Services. CMS. 2019.	G0506($62/?)
Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian in the office or other outpatient, home or domiciliary or rest home with all required elements (~ 50 min face-to-face with patient and/or family or caregiver)	99483($283/$154)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Physical and Occupational Therapy	
Therapeutic procedure, 1 or more areas, each 15 min; 97110 - therapeutic exercises to develop strength and endurance, range of motion and flexibility, 97112 - neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities, 97116 - gait training (includes stair climbing)97151	97110($30/$21) 97112($35/$22) 97116($30/$19)
Physical therapy evaluation, requiring specific components: 97161 - **low complexity**, typically, **20 min are spent face-to-face** with the patient and/or family, 97162 - **moderate complexity**, typically, **30 min are spent face-to-face** with the patient and/or family, 97163 - **high complexity**, typically, **45 min are spent face-to-face** with the patient and/or family. 97164 - **Re-evaluation of physical therapy** established plan of care, requiring specific components, typically, **20 min are spent face-to-face** with the patient and/or family.	97161($102/$52) 97162($102/$52) 97163($102/$52) 97164($70/$36)
Occupational therapy evaluation, requiring specific components: 97165 - **low complexity**, typically, 30 min are spent face-to-face with the patient and/or family, 97166 - **moderate complexity**, typically, **45 min are spent face-to-face** with the patient and/or family, 97167 - **high complexity**, typically, **60 min are spent face-to-face** with the patient and/or family. 97168 - **Re-evaluation of occupational therapy** established plan of care, requiring specific components, typically, **30 min are spent face-to-face** with the patient and/or family.	97165($99/$51) 97166($99/$51) 97167($99/$51) 97168($67/$33)
Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 min	97535($34/$23)
Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 min	97750($35/?)
Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 min	97755($39/?)
Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 min	97760($50/$25)
Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 min	97761($22)
Speech, Language, and Audiology Services	
Treatment of speech, language, voice, communication, and/or auditory processing disorder; 92507 - individual	92507($78/$52)
Evaluation of speech fluency (e.g., stuttering, cluttering)	92521($137/$74)
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) - 92522, 92523 - with evaluation of language comprehension and expression (e.g., receptive and expressive language)	92522($114/$60) 92523($235/$125)

Service	CPT/HCPCs Code(s) ($Medicare/$NV Medicaid)
Behavioral and qualitative analysis of voice and resonance	92524($112/$63)
Resource: American Medical Association. (2021). *CPT 2022 professional edition.* Chicago, IL: American Medical Association National payment amount for the non-facility price (or facility price when no non-facility price is listed) from the Physician Fee Schedule Search as of Nov 1, 2021, rounded to the nearest dollar provided only to assess potential revenue if code is used. Do not rely on these. Have your biller/coder double-check.	

State-Specific Consent Examples

Medi-Cal consent is simple and straightforward: "…inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services."[3]

Colorado Medicaid consent includes that providers must document the member's consent, either verbal or written, to receive telemedicine services and must provide the following written statements to each patient before treating that patient through telemedicine for the first time (does not apply in an emergency):

1. "That the patient retains the option to refuse the delivery of the services via telemedicine at any time without affecting the patient's right to future care or treatment and without risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;
2. That all applicable confidentiality protections shall apply to the services; and
3. That the patient shall have access to all medical information resulting from the telemedicine services as provided by applicable law for patient access to his or her medical records." ~ CO Rev Stat § 25.5-5-320 (2018)

Louisiana

- "Providers must have informed consent to deliver telemedicine/telehealth services. The consent must include the following. A recipient's authorization to receive telemedicine/telehealth services after a discussion of the following elements:
    1. The rationale for using telemedicine/telehealth in place of in-person services.
    2. The risks and benefits of the telemedicine/telehealth, including privacy-related risks.
    3. Possible treatment alternatives and those risks and benefits.
    4. The risks and benefits of no treatment."[4]

Texas

- Patient may give written or oral consent and consent must be documented in the patient's medical record but unclear what the requirements of consent are.
    1. Adult client must provide written or verbal consent to distant site provider to allow any other individual to be present during telehealth service
    2. Must provide written or electronic notification of privacy practices prior to evaluation or treatment via a telemedicine medical service and good faither effort must be made to obtain patient's written or electronic acknowledgement, including by email, of the notice.
    3. Must provide notice of how patients may file a complaint with the Board on the physician's website or with informed consent materials provided to patients prior to the telemedicine medical service.[5]

[3] Medicine: Telehealth. *State of California-Health and Human Services Agency (CA HHS).* Updated August 2020. https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele.pdf

[4] Telemedicine/Telehealth Facilitation of Outpatient Substance Use Disorder (OPSUD) Treatment Services during the COVID-19 Declared Emergency. Louisiana Department of Health. Revised Jan 2021. p. 3.

[5] Texas Administrative Code. Title 22. Part 9. Chapter 174. Subchapter A. RULE §174.4. Notice to Patients