CMS Final Rule and Telederm

PAC Pearls from the Women's Dermatologic Society

By Dr. Mark Kaufmann

There's been a lot of talk about CMS approving Telederm for reimbursement. I am going to lay out what we know so far. Below are the two G codes that will be available to us starting January 1, 2019.

G2010 - Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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).

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.

**PLEASE NOTE: These two G codes are considered communication technology codes, and NOT considered "Medicare Telehealth services." That being the case, they are NOT subject to geographic restrictions, and are NOT billed using E/M codes with modifiers.*

G2010 is essentially "store-and-forward" telederm and it requires follow-up with the patient within 24 hours of receipt. G2012 is essentially a 5-10 minute medical discussion using a "communication technology-based service." This may require further clarification, but so far, CMS has stated that the code allows "audio-only real-time telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission."

A couple of take-homes

First, these are only available to use on established patients, not on new patients. These codes are both predicated on not having seen the patient in the last 7 days, and not setting up an "in-person" appointment with them within the following 24 hours or "soonest possible appointment."

Also, "beneficiary consent" is required prior to providing a remote service, and this must be noted in the medical record for each service (the consent itself can be verbal consent, but it must be documented that it was obtained). This consent should include knowledge that you will be billing Medicare for this remote visit.

Based on what was published in the CMS Final Rule, **G2010** will reimburse $12.61, and **G2012** $14.78. These amounts are national average.

New Skin Biopsy Codes

Just a reminder, we also will have six new skin biopsy codes going into effect on January 1, 2019. Review these changes in the **August 2018 PAC Pearls**.