Telemedicine & Telehealth Reference Guide

A comprehensive resource to master telemedicine coding, compliance, and reimbursement

THIRD EDITION

AAPC

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This publication provides situational examples and explanations, of which many are taken from the Medicare perspective. The individual, however, should understand that while private payers typically take their lead regarding reimbursement rates from Medicare, it is not the only set of rules to follow.

While federal and private payers have different objectives (such as the age of the population covered) and use different contracting practices (such as fee schedules and coverage policies), the plans and providers set similar elements of the quality in common for all patients. Nevertheless, it is important to consult with individual private payers if you have questions regarding coverage.

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Telemedicine and Telehealth

Advancements in technology have improved healthcare in ways you may have never imagined. Telemedicine now allows you, as a provider, to virtually interact with your patients in a way that improves the quality and delivery of care you furnish, especially for those patients who are unable to come into your office. The convenience and instant feedback your patients receive from telemedicine visits are among the driving factors behind this rapidly growing branch of medicine.

You may hear the terms "telemedicine" and "telehealth" used interchangeably as they are broadly defined as using technology to deliver healthcare from a distance, but when you take a closer look, some subtle differences exist.

One simple way to understand these terms better is to look at telemedicine as a division of telehealth.

Telehealth refers to the use of telecommunications and information technology for healthcare, especially as a means for providers to access a patient's clinical health assessment, diagnosis, intervention, consultation, and supervision information. It can also include providing nonclinical services like conferences and education across a distance.

Telemedicine, on the other hand, exists to improve a patient's health by permitting two-way, real-time interactive communication between the patient at an originating site and the physician at a distant site. This interactive method of electronic communication includes, at a minimum, audio and video equipment, and is a cost-effective alternative to in-person medical care.

CMS uses the term telehealth in official descriptors and publications.

Examples of telemedicine and telehealth include:

- Videoconferencing including the evaluation and management of a patient by a healthcare provider
- Image transfers
- Remote monitoring of vital signs
- Telecardiology
- Teledermatology
- Telemental health
- Medical education
- Nursing call centers

Telemedicine includes different types of patient programs and services. It may involve a virtual physician visit, where a physician provides a remote consultation over the telephone or web, or it may involve devices that remotely collect and send data to a monitoring station for interpretation.

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Begin your journey by talking to your existing telehealth technology vendors, as well as other practices and healthcare facilities that use telehealth, and ask what technology and processes are working for them. You can also tap in to professional organizations for guidance; then begin to draw up a plan. Look for more insight on questions you need to answer as you plan your venture into telehealth later in this guide. You can also learn more from the American Telemedicine Association at https://www.americantelemed.org/.

Lack of Continuity

Patients with complex medical cases benefit from seeing the same provider time and time again. One problem that could arise from the use of telemedicine is that a patient may choose to switch from whichever oncologist, cardiologist, or orthopedic surgeon they're using, to a different provider, for the convenience and cost-savings. This can be problematic when it comes to receiving the best care for a chronic condition.

Important: Many facilities that offer telemedicine encounters have a caveat that states the patient must have had a pre-existing face-to-face relationship with a provider prior to initiating telemedicine treatment.

Liability

When utilizing telemedicine services, rules like these, from the Iowa Board of Medicine guidelines, illustrate a potential for tremendous liability due to their ambiguity:

- Ensure that the patient receives a physical examination, when medically necessary, prior to receiving telemedicine treatment.
- Examination need not be in person if the telemedicine encounter is sufficient to establish an informed diagnosis.

Who decides when an exam is medically necessary and/or that the encounter was sufficient or not? It's important to check your particular state guidelines and keep ambiguity and liability at the forefront of your thoughts when providing telemedicine services.

Licensing

A provider must hold a license in the state where the patient is located. This becomes tricky especially near state borders where the originating site is located in one state and the distant site is located in another.

Hardcopy Scripts

You need to have hard-copy prescriptions for certain drugs, especially the opioids. These drugs cannot be prescribed electronically or called in by phone. This creates a downside to telemedicine because the patient would still need to come in to pick up their script.

Practical Examples of Telehealth

Before we cover the regulations impacting telehealth, the details of telehealth reimbursement, and the future of telehealth, let's take a look at a few examples of telehealth services used today to help you to better understand these services.

Successful Implementation of Telemedicine and Telehealth at Your Facility

Inventions and improvements in computer technology are moving at lightning speed. New products and devices are constantly being introduced. Wonder how these changes impact you and your facility or practice? These products can be useful to you in several different ways: to capture, store, transfer, and retrieve medical data from anywhere on earth, ultimately providing you and your patients with several more options when it comes to the management or treatment of their disease.

Note: The American Hospital Association (AHA) published a report in 2019 entitled "Telehealth A Path to Virtual Integrated Care." This report examines telehealth as part of the digital healthcare revolution, explaining how telehealth is critical to the future of healthcare and how hospitals and health systems can expand telehealth access and reduce the costs of its use.

Between 2010 and 2017 the use of telehealth in hospitals has grown rapidly. The percent of hospitals fully or partially implementing computerized telehealth systems in 2010-2017 is shown in Figure 4-1.
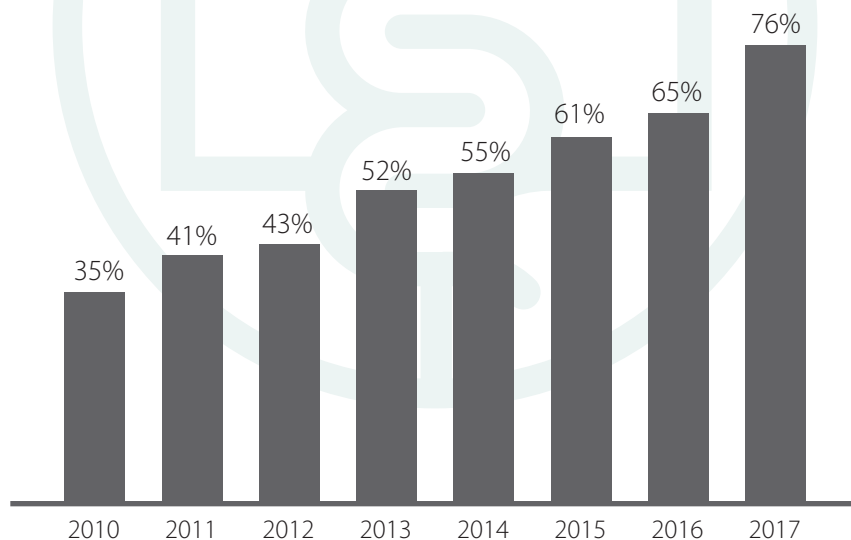
Source: 2011 to 2018 AHA Annual Survey IT Supplement

Figure 4-1: The Percent of Hospitals Utilizing Computerized Telehealth Systems from 2010-2017

How to Implement Telehealth Services

With the increasing number of facilities using telehealth to improve their patient care and outcomes, you don't want to be left behind. To grow your practice or facility and keep up with the changing needs of your consumers — both

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There are three major differences between the CPT® and HCPCS Level II codes that you should understand before you use them. First, per CPT® guidelines preceding 99441-99443, the patient or guardian must initiate the call, whereas the physician/QHP can initiate the call in G2012.

Second, G2012 is for a "technology-based service," which means it's not limited to telephone and could be computer-based. And third, the CPT® codes cover longer calls.

Question: *What limitations are there on 99441-99443 and G2012?*

Answer: The most obvious limitation is that none of these services can stem from, or result in, an E/M service for the patient. If that happens, then the calls or emails will be bundled into the E/M, and you will not be reimbursed separately for the calls or emails.

The exception to this limitation would be if your provider saw the patient for an E/M before or after the check-in for an entirely different reason unrelated to the call. So, for example, if a patient came in for an E/M related to otitis media, then the patient's mother checked in less than a week later to discuss changing the patient's asthma medication, then you would be able to bill separately for the G2012 or 99441-99443.

In addition, unlike G2012, 99441-99443 cannot be used for asynchronous services such as email. The appropriate CPT® code for that would be 99421-99423.

Question: *Do I use modifiers for the services described in codes 99441-99443 and G2012?*

Answer: Even though these services describe telemedicine services, there is no need to add a telehealth modifier to these codes. Any modifier for these codes would be situation specific — for example, if you needed to appropriately override a National Correct Coding Initiative (NCCI) edit using modifier 59 *Distinct procedural service*. Modifier use, along with reimbursement for the codes, would also be payer-dependent, so you would want to check beforehand what codes your payer will accept and how you should bill for them.

Question: *Can you bill codes 99441-99443 and G2012 incident to?*

Answer: As incident-to is typically a Medicare concept, and as Medicare doesn't cover 99441-99443, you can't bill them incident to.

However, if your practice wants to bill for telephone services provided by a qualified nonphysician who may not report E/M services, you can use 98966-98968 *Telephone assessment and management service provided by a qualified nonphysician healthcare professional …* for calls and 98970-98972 *Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days …*.

In certain circumstances, reimbursement policies for telehealth services can be altered. During a national emergency, for example, the government and private payers can relax guidelines to ensure patients get the healthcare they need. One illustration of this was the sweeping expansion of telehealth coverage taken by Medicare to aid in the healthcare needs of beneficiaries during the novel coronavirus (COVID-19) pandemic.

Note: The official name per the World Health Organization (WHO) is severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), while the name of the disease it causes is coronavirus disease (COVID-19).

During the COVID-19 outbreak, Medicare relaxed its telehealth regulations to facilitate healthcare for the elderly and others affected for the duration of the national public health emergency. CMS placed fewer restrictions on telehealth services during this time and altered physician reimbursement for telehealth services provided to Medicare patients across the country. CMS expanded the telehealth benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act.

Background: Feds Expand Telehealth by Lessening Restrictions

Former President Trump signed the Bipartisan Budget Act (BBA) in February 2018, to avert a government shutdown. Among the numerous impacts to healthcare addressed in the BBA were significant expansions and decreased restrictions to telehealth services under the section named "Subtitle C–Expanding Innovation and Technology," amending the Social Security Act.

This wide-reaching legislation enacts major changes for telehealth policy in Medicare by incorporating policies from the Senate's Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act.

What Can an Altered Telehealth Policy Mean?

For a period of time that a payer defines, the payer can remove all or some restrictions surrounding telehealth coverage for their beneficiaries. This can mean that telehealth coverage can be reimbursed for patients who require telehealth services from locations not normally reimbursed, such as within a facility or in their own home. Under the COVID-19 waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patients' places of residence. Altered policies may include patients and provider communications with a more expansive range of communication methods, such as using their smartphone for face-to-face interaction. During the COVID-19 pandemic, CMS waived the originating site and the use of HIPAA-compliant software requirement. Their waiver also explained that HHS would not conduct audits to ensure a prior relationship.

NOTES	Permanent Medicare Changes	Temporary Medicare Through December 31, 2024	Temporary Medicare Changes Through the COVID-19 PHE
	Medicare patients can receive telehealth services for behavioral/mental healthcare exit disclaimer icon in their home.	Medicare patients can receive telehealth services authorized in the calendar year 2023 Medicare Physician Fee Schedule in their home.	Medicare-covered providers may use any non-public facing application to communicate with patients without risking any federal penalties — even if the application isn't in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
	There are no geographic restrictions for originating site for behavioral/mental telehealth services.	There are no geographic restrictions for originating site for non-behavioral/mental telehealth services.	
	Behavioral/mental telehealth services can be delivered using audio-only communication platforms.	Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms.	
	Rural hospital emergency department are accepted as an originating site.	An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required.	
		Telehealth services can be provided by a physical therapist, occupational therapist, speech language pathologist, or audiologist.	

Source: https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/policy-changes-after-the-covid-19-public-health-emergency#:~:text=The%20Consolidated%20Appropriations%20Act%20of,Medicaid%20Services%20(CMS)%20website.

The Consolidated Appropriations Act of 2023

The Consolidated Appropriations Act of 2023 also addresses telehealth services after the PHE with several changes. For instance, instead of 151 days after the intended end of the PHE, (expected to be May 11, 2023), the end date of temporary Medicare waivers was moved to December 31, 2024. It is important to note that CMS is still working to catch up with the legislative language, which is why you will still read information stating the 151 grace period.

Whether you work in the public or private sector, you can submit requests to add, delete, or change HCPCS Level II codes on CMS's growing list of telehealth services. This is your opportunity to be heard.

CMS makes additions and/or deletions to telehealth services each January.

Note: Medicare uses the annual physician fee schedule proposed rule published in the summer and the final rule (published by November 1) to make reimbursement changes to telehealth services.

Important: You can submit requests to add or delete services on an ongoing basis.

You should use the following as a step-by-step guide on how to submit your suggestions for CMS consideration.

Nail Down Specifics for Submitting a Request to CMS

You need to include all of the items outlined below when requesting the addition, removal, or change of a HCPCS Level II code to the list of Medicare telehealth services:

1. List your name, address, and contact information.

2. List the HCPCS Level II code(s) that describes the service(s) you propose for addition, deletion, or change.

   Important: If you don't know the applicable HCPCS Level II code, your request should include a description of services furnished during the telehealth session.

3. Describe the type(s) of medical professional(s) providing the telehealth service at the distant site.

4. Discuss why you feel that Medicare should add, delete, or change the service.

5. Explain why you can't bill the service under the current scope of telehealth services.

   Example: Include the reason why the HCPCS Level II codes currently on the list of Medicare telehealth services would not be appropriate for billing the service requested.

6. Show evidence that supports adding the service(s) to the list on either a category 1 or category 2 basis, as explained below.

Master CMS Criteria for Submitted Requests

Select from one of the following two categories when you request adding HCPCS Level II codes to the list of Medicare telehealth services:

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.

In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site, and, if necessary, the telepresenter. They also look for similarities in the telecommunications system the provider uses to deliver the proposed service.

   ○ **Example:** The use of interactive audio and video equipment.

Category 2: Services that are not similar to the current list of telehealth services.

CMS's review of these requests will include an assessment of whether the code for the service accurately describes the service rendered via telehealth and whether the use of a telecommunications system to deliver the service produces demonstrated clinical benefit to the patient.

There are several ways telehealth video appointments can be used to treat and manage chronic conditions, including:

- Follow-up appointments to see how a patient is doing on a new diet, medications, or other modification
- Telebehavioral care and therapy
- Routine check-ins for patients with certain cancers, rheumatological diseases, diabetes, and migraines
- Explanation of test or imaging results
- Explanation of how patients use remote monitoring devices
- Nutrition and fitness counseling

Provider-to-provider Telehealth

Providers can also use telehealth to collaborate with other providers involved in the patient's care. This could be done via video chat, phone conversations, or asynchronous communication. Providers can also use telehealth with other providers for tele-mentoring on new, updated, or complex topics.

The benefits include:

- Collaboration between a patient's local primary care provider and a specialist that could be in another city, state, or region
- Reduced strain on local providers, especially if they are located in a rural area or a busy urban area with too few providers for their patient load
- The ability for consultations on patient imaging, diagnostic tests, or lab work
- Collaboration between small, local health centers and larger hospitals and universities

Asynchronous Telehealth Care to Reduce Patient Visits

Patients and providers can share important information without having to set up an appointment. This could include a patient filling out a form to gauge their symptom progression or improvement. It could be messaging updates through a secure portal. The ability to communicate asynchronously with a patient saves time and resources for your practice with fewer phone calls, less paper filing, and fewer appointments to schedule.

Examples of asynchronous telehealth care for chronic conditions include:

- Respiratory-compromised patients sending regular peak flow meter results
- Patients with neurological or rheumatological conditions sending back forms that keep track of symptoms and their severity
- Text messaging with chronically ill patients who do not have access to broadband internet
- Sending X-ray images or lab results through a secure messaging portal
- Patients uploading their food logs if on a specific dietary plan

Remote Patient Monitoring to Keep Track of Symptoms and Vital Signs

Advancements in technology allow providers and patients the flexibility to monitor their chronic conditions without routine trips into the office. Certain remote patient monitoring is also now covered by Medicare, Medicaid, and many private insurers.

There are guidelines, however, for Medicare coverage. Devices must be FDA-approved and they must be able to automatically transmit data and information to the provider without patient interference.

Many serious chronic illnesses require frequent testing and monitoring to keep the patient stable and feeling well. Remote patient monitoring options for chronically ill patients include:

- Blood sugar levels for diabetes management
- Blood pressure for cardiac patients
- Pulse oximeter readings for patients with respiratory illnesses
- Weight scales for patients being treated for obesity

1. Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Chapter 12 – Physician/Nonphysician Practitioners

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

190 - Medicare Payment for Telehealth Services

(Rev. 1, 10-01-03)

A3-3497, A3-3660.2, B3-4159, B3-15516

190.1 - Background

(Rev. 1635, Issued: 11-14-08, Effective: 01-01-09, Implementation: 01-05-09)

Section 223 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) - Revision of Medicare Reimbursement for Telehealth Services amended §1834 (go to the link and then select the applicable title) of the Act to provide for an expansion of Medicare payment for telehealth services.

Effective October 1, 2001, coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, and pharmacologic management delivered via a telecommunications system. Eligible geographic areas include rural health professional shortage areas (HPSA) and counties not classified as a metropolitan statistical area (MSA). Additionally, Federal telemedicine demonstration projects as of December 31, 2000, may serve as the originating site regardless of geographic location.

An interactive telecommunications system is required as a condition of payment; however, BIPA does allow the use of asynchronous "store and forward" technology in delivering these services when the originating site is a Federal telemedicine demonstration program in Alaska or Hawaii. BIPA does not require that a practitioner present the patient for interactive telehealth services.

With regard to payment amount, BIPA specified that payment for the professional service performed by the distant site practitioner (ie, where the expert physician or practitioner is physically located at time of telemedicine encounter) is equal to what would have been paid without the use of telemedicine. Distant site practitioners include only a physician as described in §1861(r) (go to the link and select the applicable title) of the Act and a medical practitioner as described in §1842(b)(18)(C) (go to the link and select the applicable title) of the Act. BIPA also expanded payment under Medicare to include a $20 originating site facility fee (location of beneficiary).

Previously, the Balanced Budget Act of 1997 (BBA) limited the scope of Medicare telehealth coverage to consultation services and the implementing regulation prohibited the use of an asynchronous, 'store and forward' telecommunications system. BBA 1997 also required the professional fee to be shared between the referring and consulting practitioners, and prohibited Medicare payment for facility fees and line charges associated with the telemedicine encounter.

BIPA required that Medicare Part B (Supplementary Medical Insurance) pay for this expansion of telehealth services beginning with services furnished on October 1, 2001.

Section 149 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) amended §1834 of the Act to add certain entities as originating sites for payment of telehealth services. Effective for services furnished on or after January 1, 2009, eligible originating sites include a hospital-based or critical access hospital-based renal dialysis center (including satellites); a skilled nursing facility (as defined in §1819(a) of the Act); and a community mental health center (as defined in §1861(ff)(3)(B) of the Act). MIPPA also amended§1888(e)(2)(A)(ii) of the Act to exclude telehealth services furnished under §1834(m)(4)(C)(ii)(VII) from the consolidated billing provisions of the skilled nursing facility prospective payment system (SNF PPS).

the initial inpatient consultation via telehealth cannot be the physician or practitioner of record or the attending physician or practitioner, and the initial inpatient telehealth consultation would be distinct from the care provided by the physician or practitioner of record or the attending physician or practitioner. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. Initial and follow-up inpatient telehealth consultations are subject to the criteria for inpatient telehealth consultation services, as described in section 190.3 of this chapter.

190.3.6 – Payment for Diabetes Self-Management Training (DSMT) as a Telehealth Service
(Rev. 4173, Issued: 11-30-18, Effective: 01-01- 19, Implementation: 01-02-19)

Individual and group DSMT services may be paid as a Medicare telehealth service. Before 03-11-2016, this manual provision required that 1 hour of the 10 hour DSMT benefit's initial training must be furnished in-person to allow for effective injection training. Because injection training is not always clinically indicated, we are revising this provision to permit all 10 hours of the initial training and the two (2) hours of annual follow-up training to be furnished via telehealth in those cases when injection training is not applicable. The in-person injection training, when provided, may be furnished through either individual or group DSMT services. By reporting place of service (POS) 02 or the – GT or –GQ modifier with HCPCS code G0108 (Diabetes outpatient self-management training services, individual, per 30 minutes) or G0109 (Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes), the distant site practitioner attests that the beneficiary has received or will receive 1 hour of in-person DSMT services for purposes of injection training when it is indicated during the year following the initial DSMT service or any calendar year's 2 hours of follow-up training.

As specified in 42 CFR 410.141(e) and stated in Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, section 300.2, individual and group DSMT services may be furnished by a physician, other individual, or entity that furnishes other items or services for which direct Medicare payment may be made and that submits necessary documentation to, and is accredited by a national accreditation organization approved by CMS. However, consistent with the statutory requirements of section 1834(m)(1) of the Act, as provided in 42 CFR 410.78(b)(1) and (b)(2) and stated in section 190.6 of this chapter, Medicare telehealth services, including individual and group DSMT services furnished as a telehealth service, could only be furnished by a physician, PA, NP, CNS, CNM , clinical psychologist, clinical social worker, or registered dietitian or nutrition professional, as applicable.

190.3.7 – Payment for Telehealth for Individuals with Acute Stroke
(Rev. 4173, Issued: 11-30-18, Effective: 01-01- 19, Implementation: 01-02-19)

Section 50325 of the Bipartisan Budget Act of 2018 amended section 1834(m) of the Act by adding a new paragraph (6) that provides special rules for telehealth services furnished on or after January 1, 2019, for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke (acute stroke telehealth services), as determined by the Secretary. Specifically, section 1834(m)(6)(A) of the Act removes the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. Section 1834(m)(6)(B) of the Act specifies that acute stroke telehealth services can be furnished in any hospital, critical access hospital, mobile stroke units (as defined by the Secretary), or any other site determined appropriate by the Secretary, in addition to the current eligible telehealth originating sites. Section 1834(m)(6)(C) of the Act limits payment of an originating site facility fee to acute stroke telehealth services furnished in sites that meet the usual telehealth restrictions under section 1834(m)(4)(C) of the Act. These are identified in Section 190.1 of this chapter.

Effective for claims with dates of service on and after January 1, 2019, contractors shall accept new informational HCPCS modifier G0 (G zero), to be used to identify Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke. Modifier G0 is valid for all:

- Telehealth distant site codes billed with Place of Service (POS) code 02 or Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
- Telehealth originating site facility fee, billed with HCPCS code Q3014.

190.4 - Conditions of Payment
(Rev. 1, 10-01-03)

1. Technology

For Medicare payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the distant site physician or practitioner and the Medicare beneficiary. As a condition of payment, the patient must be present and participating in the telehealth visit.

https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes

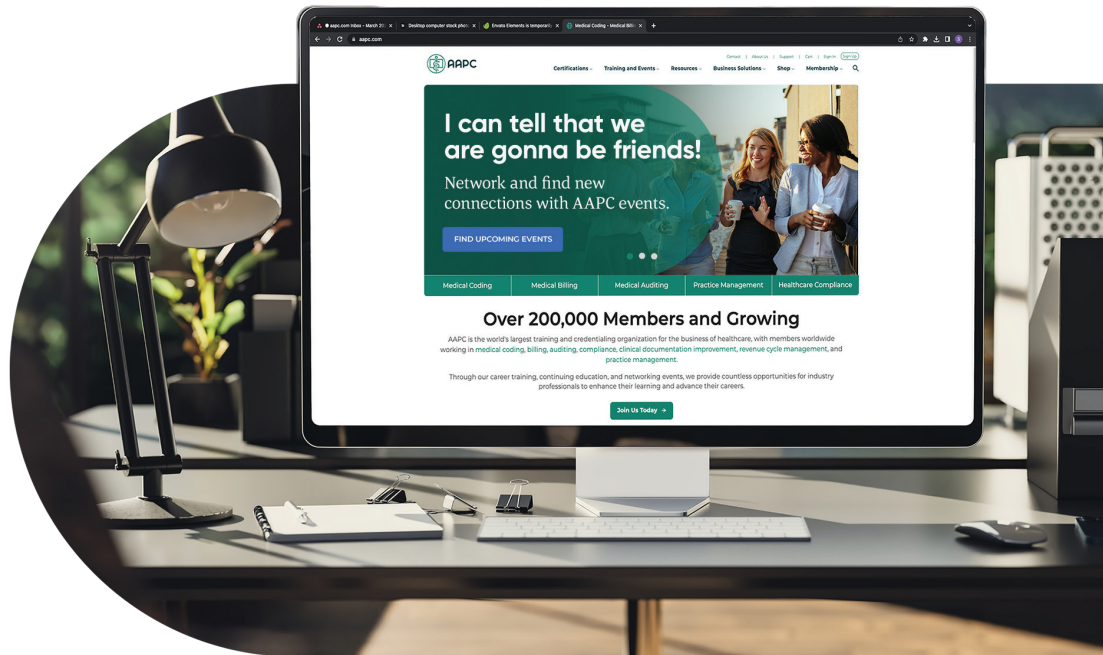| Code	Short Descriptor	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
0362T	Bhv id suprt assmt ea 15 min	-	-
0373T	Adapt bhv tx ea 15 min	-	-
77427	Radiation tx management x5	-	-
90785	Psytx complex interactive	Yes	-
90791	Psych diagnostic evaluation	Yes	-
90792	Psych diag eval w/med srvcs	Yes	-
90832	Psytx w pt 30 minutes	Yes	-
90833	Psytx w pt w e/m 30 min	Yes	-
90834	Psytx w pt 45 minutes	Yes	-
90836	Psytx w pt w e/m 45 min	Yes	-
90837	Psytx w pt 60 minutes	Yes	-
90838	Psytx w pt w e/m 60 min	Yes	-
90839	Psytx crisis initial 60 min	Yes	-
90840	Psytx crisis ea addl 30 min	Yes	-
90845	Psychoanalysis	Yes	-
90846	Family psytx w/o pt 50 min	Yes	-
90847	Family psytx w/pt 50 min	Yes	-
90853	Group psychotherapy	Yes	-
90875	Psychophysiological therapy	-	Non-covered service
90901	Biofeedback train any meth	-	-
90951	Esrd serv 4 visits p mo <2yr	-	-
90952	Esrd serv 2-3 vsts p mo <2yr	-	-
90953	Esrd serv 1 visit p mo <2yrs	-	-
90954	Esrd serv 4 vsts p mo 2-11	-	-
90955	Esrd srv 2-3 vsts p mo 2-11	-	-
90956	Esrd srv 1 visit p mo 2-11	-	-
90957	Esrd srv 4 vsts p mo 12-19	-	-
90958	Esrd srv 2-3 vsts p mo 12-19	-	-
90959	Esrd serv 1 vst p mo 12-19	-	-
90960	Esrd srv 4 visits p mo 20+	-	-
90961	Esrd srv 2-3 vsts p mo 20+	-	-
90962	Esrd serv 1 visit p mo 20+	-	-
90963	Esrd home pt serv p mo <2yrs	-	-
90964	Esrd home pt serv p mo 2-11	-	-

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