# Telemedicine and COVID-19

## Based on March 30, 2020 expansion

## Take care of your patients while allowing them to stay at Home


*Researched and Presented by:*

*Nancy M. Enos, FACMPE, CPC-I, CPMA, CEMC, CPC*

*Mike Enos, CPC, CPMA, CPC-I, CEMC*


ENOS Medical Coding

Approved Instructor

# Disclosures

This webinar is to educate providers about the new CMS telehealth rules for the current COVID-19 event.

The rules are effective March 1st, 2020 for the duration of the COVID-19 Pandemic

Please follow the CMS, CDC and AMA websites for up to date information. The AMA assumes no liability for the data contained herein.

Enos Medical Coding does not provide legal advice. The information in this presentation is based on the coding guidelines in the Current Procedural Terminology (CPT) Manual published by the American Medical Association (AMA) and Evaluation and Management Coding Guidelines from the Centers for Medicare and Medicaid (CMS)

# About the Speaker

Nancy@enosmedicalcoding.com
401-486-8222

**Nancy M Enos, FACMPE, CPMA, CPC-I, CEMC** is an independent consultant with the MGMA Health Care Consulting Group and a principal of Enos Medical Coding. Mrs. Enos has 40 years of experience in the practice management field. Nancy was a practice manager for 18 years before she joined LighthouseMD in 1995 as the Director of Physician Services and Compliance Officer. In July 2008 Nancy established an independent consulting practice, Nancy Enos Medical Coding (www.nancyenoscoding.com)

As an Approved PMCC and ICD-10 Instructor by the American Academy of Professional Coders, Nancy provides coding certification courses, outsourced coding services, chart auditing, coding training and consultative services and seminars in CPT and ICD-10 Coding, Evaluation and Management coding and documentation, and Compliance Planning. Nancy frequently speaks on coding, compliance and reimbursement issues to audiences including National, State and Sectional MGMA conferences, and at hospitals in the provider community specializing in primary care and surgical specialties.

Nancy is a Fellow of the American College of Medical Practice Executives. She serves as a College Forum Representative for the American College of Medical Practice Executives.

# Agenda

- Expanded CPT codes for Telemedicine
- Clarification on Waivers regarding Patient Status
- Provider definitions for Physician and Non-physician services
- Modifiers for Telemedicine
- Technology requirements by code category
- Place of Service codes for Telemedicine Claims

- Detailed handouts will be provided with the slides: FAQs, Reimbursement amounts and Telemedicine grid.
- Please hold questions from the queue until the end of the presentation, as your questions will likely be covered.
- Additional Q&A will be held at the end of the presentation

# What is Telehealth/Telemedicine?

- Telehealth refers to the exchange of medical information from one site to another through electronic communication to improve a patient's heath.

- Telemedicine is the practice of medicine using technology to deliver care at a distance.

# COVID-19 Regulatory Changes

On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued guidance on Secretary Azar's waiver authority that broadens access to Medicare telehealth services.

Effective March 1, 2020 and for the duration of the COVID-19 Public Health Emergency, CMS will allow all qualified healthcare providers to care for patients remotely and bill Medicare and Medicaid, without meeting the existing requirements that will be covered in the following slides

On March 30, 2020 Expanded Regulations were issued.

Check with other payers as their policies will likely change in accordance with CMS (this updated changed the effective date from 3/6/2020 back to 3/1/2020)

# Medicare Requirements

- Waived:
  - Medicare requires the GT modifier
  - Only Telehealth codes (original 101 CPT codes)

- New Criteria
  - Modifier 95, indicating that the service rendered was performed via telehealth
  - POS 11 for Office
  - The service must be patient initiated
  - The physician performs and documents the key components (or time counseling) and technology meets the conditions of a telemedicine visit- then you can bill and E/M visit

# Geographic Restrictions

- Waived
  - The patient must be in a HPSA (healthcare professional shortage area)
  - a patient must be located in a rural area
- New Criteria
  - Patients can receive telehealth services in non-rural areas

# Available to Patients in their home

- Waived:
  - The patient should be located at a qualified originating site and must be a physician's office or other authorized healthcare facility
  - The visit is conducted by the facility with the performing physician in another location

- New Criteria:
  - The waiver temporarily eliminates the requirement for the originating site and allows Medicare to pay for telehealth services when beneficiaries are ***in their homes*** or any setting of care.

# Waiving communication restrictions

- Waived:
  - Telemedicine services must be rendered using a HIPAA compliant telemedicine platform.

- New Criteria:
  - A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use **any non-public facing remote communication product** that is available to communicate with patients
  - The waiver allows use of telephones that have audio and video capabilities (smart phones)
  - Without video, use the telephone call CPT codes can be found in upcoming slides

# HIPAA Compliance

Covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that (office of civil rights) OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications.

Under this Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

# Privacy Issues Using FaceTime

OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the *good faith* provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

Telehealth services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement. Verbal consent documents in patients' chart is acceptable.

The HHS.gov Health Information Privacy Notice can be viewed on their website

Please note HIPAA still applies to all other practice functions.

# HIPAA Compliance

- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies.
- Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules

# Copays Can Be Waived

The HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to **reduce or waive cost-sharing** for telehealth visits paid by federal healthcare programs.

The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

# Eligible Providers

- In order to deliver telehealth services, a clinician must still be a Medicare “qualified provider.”
- CMS has temporarily waived the requirements that physicians or other healthcare professionals hold licenses in the state in which they provide services if they have an equivalent license from another state.
- Retired providers who have an inactive license may resume work within the scope of their practice, provided their out-of-state, inactive or expired license was in good standing.

# Eligible Providers

- A range of providers, such as doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, licensed clinical social workers, registered dietitians and nutrition professionals will be able to offer **telehealth** to their patients.
- Recognized, licensed providers may vary, check your State regulations.

# Non-Clinician Eligible Providers

- A range of providers, such as doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, licensed clinical social workers, registered dietitians and nutrition professionals will be able to offer **telehealth** to their patients.
- Recognized, licensed providers may vary, check your State regulations. Certain clinicians are not included as a provider type that can furnish telehealth as a covered service to Medicare beneficiaries under this legislation.
- Clinicians who may not independently bill for evaluation and management visits, for example – **physical therapists, occupational therapists, speech language pathologists, clinical psychologists.**
- However, they can provide these online visits which represent patient-initiated email or patient portal communication and bill the following codes.

# Patient Status

- The new rules do not enforce the established relationship requirement that a patient have seen a provider within the last three years.
- New patients may be problematic when you have to document 3/3 elements (History, Exam and MDM) in order to bill a new patient code 99201-99205
- Documentation to support the level of service, or **time**, must be considered

- Virtual Check-in services can be provided to both new and established patients.

# Billing for Telehealth services

- **During the pandemic, individuals can use commonly available interactive apps with audio and video capabilities to visit with their clinician.**

- Medicare telehealth services are generally billed as if the service had been furnished in-person. Medicare pays the same amount for telehealth services as it would if the service were furnished in person

- **Providers can evaluate beneficiaries who have audio phones only using telephone and virtual check in codes**

- 4/3/2020 Special Update:
  - For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) equal to what it would have been had the service been furnished in-person
  - Modifier 95, indicating that the service rendered was actually performed via telehealth. (correction issued 4/3/2020

# Covered Codes

- Reimbursement will be allowed for any telehealth covered CPT code **even if unrelated** to treatment of a COVID-19 diagnosis, screen or treatment
- March 17, 2020: There are 101 CPT codes designated as eligible for telehealth payment.
  - Office or other outpatient visits
  - Subsequent hospital and nursing facility care visits
  - Psychotherapy
  - Health and behavioral assessment and interventions
  - End-stage renal disease services
  - ***Preventive Medicine visits are not covered, for any age***

# March 30, 2020 Expansion

- March 30, 2020: CMS will now pay for more than 80 additional services when furnished via telehealth.
- These include emergency department visits, initial nursing facility and discharge visits and home visits.
- CMS is allowing telehealth to fulfill face-to-face visit requirements for clinicians to see patients in inpatient rehabilitation facilities; hospice and home health.

# Expanded Services

- Emergency Department Visits 99281-99285 (POS 23)
- Observation Discharge 99217 (POS 19)
- Initial Observation Care 99218-99220 (POS 19)
- Subsequent Observation care 99224-99226 (POS 19)
- Same day Admission/Discharge 99234-99236 (POS 19/21)
- Initial Inpatient care 99221-99223 (POS 21)
- Hospital discharge Management 99238-99239 (POS 21)
- Initial Nursing Facility visits 99305-6 (POS 31)
- Nursing Facility Discharge 99315-99316 (POS 31)
- Critical Care 99291-99292 (POS 21)

# Expanded Services

- Domiciliary, Rest Home or Custodial Care (POS 13)
  - –New 99327-99328
  - –Established 99334-99337
- Home visits New patient 99341-99345 (POS 12)
- Home visits Established patient 99347-99350 POS 12)
- Inpatient Neonatal and Pediatric critical care (POS 21)
  - –Initial 99468 99471 and 99475 (based on age)
  - –Subsequent 99469,99472 and 99476 (based on age)
  - –NICU 99477-99480 based on body weight

# Expanded Services

- 99486 Cognitive Assessment (POS 11)
- 90853 Group Psychotherapy (POS 11)
- 90952 – 90962 End-Stage Renal Disease (POS 11)
- 96130-96139 Psychological or neuropsychological test (POS 11)

- Not included:
  - Therapy services furnished by physical therapists, occupational therapists and speech-language pathologists.
  - Radiation Treatment Management Services

# Removal of frequency limitations on Medicare telehealth

- Subsequent inpatient visits (CPT 99231-99233), subsequent skilled nursing visits (CPT 99307-99310), and critical care consult codes (CPT G0508-G0509) no longer have limitations on the number of times they can be billed.
- Previously the frequency limit was once per 30 days.
- From March 1, 2020 for the duration of the PHE the frequency restrictions are removed.

# Virtual Check-Ins

- Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care.
- In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner.
- Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.
- **3/30/2020 expansion: Virtual check-ins.** Clinicians can provide virtual check-in services (HCPCS G2012, G2010) to both new and established patients. Previously, these services were limited to established patients only.
- POS 11

# Virtual Check-Ins

- **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 ($14.80)

- **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 ($12.27)

- CMS is currently waiving all Telemedicine modifiers. Modifier GT would be appropriate for other payers

# E-Visits for Clinicians

- Clinicians who **may not** independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

- **G2061**: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes ($12.27)
- **G2062**: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes ($21.65)
- **G2063**: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes. ($33.92)

# Online digital evaluation and management

| Code | Average Payment | Description |
|---|---|---|
| **99421** | **$13.35** | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes |
| **99422** | **$27.43** | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes |
| **99423** | **$43.67** | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes |

# Online digital evaluation and management

**INCLUDES**

Cumulative service time within a 7 day time frame needed to evaluate, assess, and manage the patient:
- Ordering of tests
- Prescription generation
- Separate digital inquiry for new and unrelated problem
- Subsequent communication that is digitally supported (i.e., email, online, telephone)

Digital service initiated by an established patient

**EXCLUDES**

*Clinical staff time*

*Digital evaluation by a qualified nonphysician health care professional (98970-98972)*

*Digital evaluation peformed with separately reportable E&M services during same time frame for new or established patient:*
- *Inquiries related to previously completed procedure and within the postoperative period*
- *INR monitoring (93792-93793)*
- *Office consultation (99241-99245)*
- *Office or other outpatient visit (99201-99205, 99212-99215)*
- *Patient management services (99339-99340, 99374-99380, [99091], 99487-99489, 99495-99496)*

*Digital service less than 5 minutes*

*Use of code more than one time in 7 days*

# How is telemedicine different from virtual check-ins and e-visits?

- A virtual ***check-in*** pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a ***visit*** furnished via Medicare telehealth is treated *the same as an in-person visit*, and can be billed using the code for that service, using **Modifier 95** to indicate the service was performed via telehealth.
- An e-visit is when a beneficiary communicates with their doctors through online patient portals.

# Physician Telephone Services*

**For calls without video capability, you can report:**

**99441** telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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*** ($14.44)

**99442 …** 11-20 minutes of medical discussion ($28.15)

**99443 …** 21-30 minutes of medical discussion ($41.14)

***Summarize discussion and document time spent***

**We are finalizing, on an interim basis for the duration of the PHE for the COVID-19 pandemic, separate payment for CPT codes 98966-98968 and CPT codes 99441-99443.

(page 125 CMS-**1744-IFC )**

# Nonphysician Telephone Services

**98966** Telephone assessment and management service provided by a qualified nonphysician health care professional (e.g., Nurse) to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment***; 5-10 minutes of medical discussion*** ($14.44)

**98967** … 11-20 minutes of medical discussion ($28.15)

**98968** … 21-30 minutes of discussion ($41.14)

***Summarize the discussion and document time spent***

# Summary of Medicare Telemedicine Services

| Type of service | CPT Code | What is the service? |
|---|---|---|
| **Medicare Telehealth Visits** | 99201-99215 | A visit with a provider that uses real-time audio and video telecommunications systems between a provider and a patient |
| **Virtual Check-In** | **G2012**<br>**G2010** | A brief check in with a provider with a telephone or other telecommunication device to decide whether an office visit is warranted OR a remote evaluation of recorded video or images submitted by a patient. |
| **E-Visits** | 99421<br>99422<br>99423<br>**G0261**<br>**G0262**<br>**G0263** | Communication between a patient and their provider through an online portal (based on cumulative time spent over 7 day period) |
| **Telephone only** | 99441<br>99442<br>99443<br>98966<br>98967<br>98968 | Telephone evaluation by a physician or non-physician (based on time spent) |

# Documentation Requirements for Telemedicine

Documentation Guidelines and **key components** of E/M Services:

- History
- Exam
- Medical Decision Making;

  OR

- Time-based E/M Services

# E & M Level of Service Breakdown

**S** Level of History

**O** Level of Exam

**A P** Level of Decision Making

---

## Level of Service

# History

## History of Present Illness

**Location, severity, timing, modifying factors, quality, duration, context, associated signs and symptoms**

**2 Levels**

| | |
|---|---|
| **Brief** 1-3 elements | **Extended** 4 elements or status of 3 chronic conditions |

# History

## Review of Systems

- ❑ Constitutional
- ❑ Eyes
- ❑ Ears
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Gastrointestinal
- ❑ Musculoskeletal
- ❑ Integumentary
- ❑ Neurological
- ❑ Psychiatric
- ❑ Endocrine
- ❑ Hematological/Lymphatic
- ❑ Allergic/Immunology

- Both positive and negative patient answers must be documented in the HPI to be relevant
- 4 Levels:
  - **Problem Focused**: none
  - **Expanded Problem Focused**: Pertinent to Problem, 1 system
  - **Detailed**: 2-9 Systems, Extended
  - **Comprehensive**: Complete, 10 systems, ***or*** some systems with statement "all others negative"
  - Medicare carriers do include "all others negative" on their audit templates but have pulled back in allowing broad use of this phrase

# Past, Family and/or Social History

**Past History -**Review of patient's past illnesses, operations, allergies, medications, details of pregnancy or birth, etc.

**Family History -**Review of patient's parents/siblings medical events, diseases, health status, cause of death, or hereditary conditions that may place the patient at risk.

**Social History-** Review of social factors, school/daycare settings, smoking, alcohol/drug use, occupation that may impact the patient's health.

# History

To select the level, all elements must be met

| History of Present Illness (HPI) | Review of Systems (ROS) | Past, Family, and/or Social History (PFSH) | Level of History |
|---|---|---|---|
| Brief (1-3 elements) | No ROS | No PFSH | **Problem Focused** |
| Brief (1-3 elements) | Problem Pertinent (1 system) | No PFSH | **Expanded Problem Focused** |
| Extended (4 or more) | Extended (2-9 systems) | Pertinent (1 history) | **Detailed** |
| Extended (4 or more) | Complete (10 or more) | Complete (2-3 history areas) | **Comprehensive** |

# Physical Exam

1995 Examination – may be body areas or organ system

**Body Areas**

- Head, including face
- Neck
- Chest, including breasts
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine

Each extremity

- Left Upper
- Right Upper
- Left Lower
- Right Lower

•Only document observations made during the remote visit

**Organ Systems**

- Constitutional
- Eyes
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/ immunologic

# Documentation

- A
  - Assessment
  - Number of Diagnoses  (must be specific)
  - Complexity and Amount of Reviewed Data
- P
  - Treatment Plan Options
  - Risk of Complications

# Medical Decision Making

**Medical decision making is determined by considering the following factors:**

- The number of diagnoses and/or management options that must be considered;
- The amount and/or complexity of data that must be obtained, reviewed, and analyzed;
- The risk of significant complications, morbidity, and/or mortality associated with the patient's presenting problem(s), or management options.

# Medical Decision Making

The table below shows the elements for each level of medical decision making. Note that to qualify for a given level of medical decision making complexity, **two of the three** elements must be either met or exceeded.

| # of dx or mgmt options | Amt and/or complexity of data | Risk of Complications | Type of Decision Making |
|---|---|---|---|
| Minimal (≤1) | Minimal (≤1) | Minimal | **Straightforward** |
| Limited (2) | Limited (2) | Low | **Low complexity** |
| Multiple (3) | Moderate (3) | Moderate | **Moderate complexity** |
| Extensive (≥4) | Extensive (≥4) | High | **High complexity** |

# TIME

- For coding purposes, face-to-face time for office visits is defined as only that time that the physician spends face-to-face with the patient and/or family.
- Now, ***Face-to-Face time*** can mean "***FaceTime***"
- If the level of service is reported based on time spent counseling and/or coordinating of care, the documentation must show:
  - ❖The total length of the encounter
  - ❖That greater than 50% of the time was spent counseling
  - ❖The content of the counseling or coordination of care

# New Office Patient

**Required Components: 3/3**

| E/M | Hx | Exam | MDM | Time |
|---|---|---|---|---|
| 99201 | PF | PF | SF | 10 |
| 99202 | EPF | EPF | SF | 20 |
| 99203 | Detailed | Detailed | Low | 30 |
| 99204 | Comp | Comp | Moderate | 45 |
| 99205 | Comp | Comp | High | 60 |

# Established Office Patient

**Required Components: 2/3**

| E/M | Hx | Exam | MDM | Time |
|---|---|---|---|---|
| 99212 | PF | PF | SF | 10 |
| 99213 | EPF | EPF | Low | 15 |
| 99214 | Detailed | Detailed | Moderate | 25 |
| 99215 | Comp | Comp | High | 40 |

# Medicare Modifier Update

- As of 3/30/2020, Medicare states: Because we currently use the POS code on the claim to identify Medicare telehealth services, we are finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.

- Page 15 CMS **MS-1744-IFC**

# Place of Service Update

- March 30, 2020
- CMS update: We recognize the rapid transition to telemedicine does not decrease the overhead
- To implement this change on an interim basis, we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person.

# Telemedicine Modifier

- **Modifier 95** Synchronous Telemedicine Service Rendered Via a **Real-Time Interactive Audio and Video** Telecommunications System
- **Synchronous telemedicine service** is defined as a real-time interaction between a physician and a patient who is located at a distant site.
- The totality of the communication of information exchanged must be of an amount and nature that would be sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

# Telehealth Modifiers

- Check with payers to verify their requirements for modifiers
  - –GT- HCPCS modifier
  - –95- CPT modifier
- Most commercial insurance accepts the 95 modifier

| Code | Service description |
|---|---|
| Modifiers | |
| GT | Via interactive audio and video telecommunication systems |
| 95 | Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system |
| G0 | Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke |

# State Medicaid Programs

- States have broad flexibility to cover telehealth through Medicaid.
- No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.
- A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

# Payer Policies

- United Health click here
- Blue Cross Blue Shield Coronavirus Updates
- Molina Healthcare COVID-19
- Humana Patient Responsibility
- Medicare Coverage of Services
- Cigna Coronavirus Resource Center
- Aetna Provider Resources

# Diagnosis Coding

**Conditions that will support medical necessity**

- As always, your E/M codes must be supported by diagnosis codes that report symptoms or confirmed illness to establish the medical necessity of the service, and support the level of service
- For patients under your care for chronic conditions that must be assessed, this is straightforward
- For patients who have symptoms, just report the symptom codes

# Diagnosis coding is allowed for all issues

- The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient.
- This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely.
- For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

# ICD-10 Coding for Coronavirus

- On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern. As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus.

- **U07.1, COVID-19 (test confirmed)***
- **Without a positive test**
  - **Z71.84** Encounter for Health counseling related to Travel
  - **Z71.1** Person with feared health complaint in whom no diagnosis is made

***effective April 1, 2020**

# Key Takeaways

- Effective for services starting **March 1, 2020** and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.
- These visits are **considered the same as in-person visits and are paid at the same rate** as regular, in-person visits.
- Starting March 1, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries **in all areas of the country in all settings.**

# Key Takeaways

- While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility **and in their home.**

# Key Takeaways

- The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing **flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits** paid by federal healthcare programs.
- To the extent the 1135 waiver requires an established relationship, **HHS will not conduct audits to ensure that such a prior relationship existed** for claims submitted during this public health emergency.

# Resources

## Covered codes by provider and service type

| Type of Service | What is the Service? | Who is the Provider? | HPCS/CPT Code | Patient relationship with Provider |
|---|---|---|---|---|
| MEDICARE Telehealth Visits | A visit with a provider that uses telecommunication systems between a provider and a patient. | Physicians and other Qualified Health care Professional | Common telehealth services include: 99201-99215 (Office or other outpatient visits) G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) | For new* or established patients.*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency |
| Virtual check-in or Telephone call | A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an establish patient. | Physicians and other Qualified Health care Professional | HCPCS code G2012 (brief check-in) HPCPS code G2010 (store and forward data) | For established patients. |

# Resources

## Covered codes by provider and service type continued

| Type of Service | What is the Service? | Who is the Provider? | HPCS/CPT Code | Patient relationship with Provider |
|---|---|---|---|---|
| Telephone E/M Service | Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services, 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 | Physicians and other Qualified Health care Professional | 99441 – 5-10 minutes<br>99442 – 11-20 minutes<br>99443 – 21-30 minutes | For established patients. |
| | Telephone assessment and management service provided by a qualified nonphysician health care professional not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment | Qualified nonphysician health care professional | 98966 – 5-10 minutes<br>98967 – 11-20 minutes<br>98968 – 21-30 minutes | For established patients. |

# Resources

## Covered codes by provider and service type continued

| Type of Service | What is the Service? | Who is the Provider? | HPCS/CPT Code | Patient relationship with Provider |
|---|---|---|---|---|
| E-Visits | On-line medical evaluation services are non-face-to-face encounters originating from the established patient to the physician or other qualified health care professional for evaluation or management of a problem utilizing internet resources. The service includes all communication, prescription, and laboratory orders with permanent storage in the patient's medical record. The service may include more than one provider responding to the same patient and is only reportable once during seven days for the same encounter. Do not report these codes if the online patient request is related to an E/M service that occurred within the previous seven days or within the global period following a procedure. | Physicians and other Qualified Health care Professional | 99421<br>99422<br>99423 | For established patients. |
| | Qualified nonphysician health care professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes, 11-20 minutes and 21 or more | Clinicians who may not independently bill for evaluation and management visits (ex. Physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can bill G2061-G2063 | G2061<br>G2062<br>G2063 | For established patients. |

# Resources:

- http://coronavirus.gov/ - The CDC site devoted to COVID-19 information, updates, information for providers, community resources, and frequently asked questions.
- https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet - CMS fact sheet announcing expansion of telehealth services on March 17th.
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth - Health Information Privacy Notice
- Frequently Asked Questions – FAQ posted by CMS
- https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf - Special (**FREE**) edition of CPT Assistant with guidance on the new CPT code
- AMA Telehealth grid: https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf

# AMA Resources

## Telehealth Visits

Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M)

| Code | Description |
|---|---|
| **CPT Code 99201-99205**<br>POS 02 for Telehealth (Medicare)<br>Modifier 95 (Commercial Payers) | Office or other outpatient visit for the evaluation and management of a new patient |
| **CPT Code 99211-99215**<br>POS 02 for Telehealth (Medicare)<br>Modifier 95 (Commercial Payers) | Office or other outpatient visit for the evaluation and management of an established patient |

*A list of all available codes for telehealth services can be found here:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

**Please note**—Check with your payer to determine the appropriate Place of Service (POS) code for your telehealth visits. The AMA is aware that some commercial payers are requiring the use of POS 02—Telehealth (The location where health services and health related services are provided or received, through a telecommunication system.) This is important to ensure your telehealth E/M visits are accurately associated with the care of patients for suspected or diagnosed COVID-19.

# Online Digital Visits

Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (via patient portal, smartphone).

| Code | Description |
|---|---|
| **CPT Code 99421** | Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes |
| **CPT Code 99422** | 11-20 minutes |
| **CPT Code 99423** | 21 or more minutes |
| **CPT Code 98970*** | 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; 5-10 minutes |
| **CPT Code 98971*** | 11-20 minutes |
| **CPT Code 98972*** | 21 or more minutes |
| **HCPCS Code G2061** | Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes |
| **HCPCS Code G2062** | 11-20 minutes |
| **HCPCS Code G2063** | 21 or more minutes |
| **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 |
| **HCPCS Code 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 |

* CPT codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063.

# Telephone Evaluation and Management Service

CPT codes to describe telephone evaluation and management services have been available since 2008. Relative values are assigned to these services. **Medicare still currently considers these codes to be non-covered**. However, private payers may pay for these services.

| Code | Description |
|---|---|
| **CPT Code 99441** | Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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 |
| **CPT Code 99442** | 11-20 minutes of medical discussion |
| **CPT Code 99443** | 21-30 minutes of medical discussion |

*** The AMA is urging CMS to begin covering these services under Medicare immediately in light of the novel coronavirus emergency.**

# Appendix

**Telehealth Educational Materials which may be useful <u>AFTER</u> the emergency measures expire**

# What is Telehealth?

- There are many new medical tech terms being used today that the average patient may not be familiar with. For example, **a common misunderstanding** is that the terms telemedicine, telecare, and telehealth are interchangeable.
- The truth is that each of these terms refers to a different way of administering health care via existing technologies or a different area of medical technology. To clarify the **subtle differences between these three terms**, we have provided a detailed definition of each.
-

# Telehealth

- According to CMS, telehealth services must be provided via an interactive audio and video telecommunications system that allows for real-time communication between the provider and the beneficiary. The exceptions are Alaska and Hawaii, where asynchronous technology — defined as the transmission of medical information to the distant site and reviewed later by the physician or practitioner — is permitted in federal telemedicine demonstration programs.
- Telehealth technology enables the remote diagnoses and evaluation of patients in addition to the ability to remote detection of fluctuations in the medical condition of the patient at home so that the medications or the specific therapy can be altered accordingly. It also allows for e-prescribe medications and remotely prescribed treatments.

# Telehealth Sites

- The originating site is where the patient is at the time of the telehealth encounter
- Examples are hospitals, rural health clinics, FQHCs, skilled nursing facilities and community mental health centers
- The distant site is where the provider delivering the service is located. These providers include:
  - Physicians, Nurse Practitioners, Physician Assistants, Clinical Nurse specialists, Clinical psychologists and clinical social workers, registered dieticians or nutritionists

# Documentation requirements

Documentation requirements for a telehealth service are the same as for a face-to-face encounter. The information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.

It is advisable to follow local Medicare Administrative Contractor (MAC) guidance for final instructions on billing and documentation requirements for telehealth services. Additionally, private payers may follow the guidelines set forth by Medicare or may have their own.

As telehealth becomes more efficient and improves patient outcomes, more services are likely to be approved for reimbursement. As more payers cover telehealth services, payment policies and criteria will change, so keep a watchful eye on the situation.

# Telehealth example

A Medicare patient presents to a rural health clinic complaining of a headache, nausea and vomiting. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with the provider using audiovisual equipment. The provider performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider.

If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders the patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam and moderate medical decision-making. Also included in the documentation is information stating that the service was provided through telehealth, the location of the patient and the provider, and the names of any other staff involved in the service.

For the distant site in this example, CPT code 99202 is billed with POS code 02 for the professional provider's service. The originating site should report HCPCS code Q3014 for the services provided.

# 2019 Telemedicine CPT Codes

- **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
- Physicians or other qualified practitioners review photos or video information submitted by the patient to determine if a visit is required. The service may be provided to an established patient when a related evaluation and management (E/M) service has not been provided in the previous seven days and may not lead to an E/M service within the next 24 hours or soonest available appointment.

# 2019 Telemedicine CPT Codes

- **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. Avg payment $13.35
- A physician or other qualified health care professional conducts a virtual check-in, lasting five to ten minutes, for an established patient using a telephone or other telecommunication device to determine whether an office visit or other service is needed. The service may be provided when a related evaluation and management (E/M) service has not been provided in the previous seven days and it may not lead to an E/M service within the next **24** hours or soonest available appointment.

# Telehealth Modifiers

- CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers.
- However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims:
  1. In cases when a telehealth service is furnished via **asynchronous** (*store and forward*) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the **GQ modifier** is required.
  2. When a telehealth service is billed under **CAH Method II**, the **GT modifier** is required.
  3. When telehealth service is furnished for purposes of diagnosis and treatment of an **acute stroke**, the **G0 modifier** is required.