Telemedicine and COVID-19

Based on April 30, 2020 expansion

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

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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

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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 served as a College Forum Representative for the American College of Medical Practice Executives.

Agenda

- E/M services
- Telephone Services
- Communication Technology Based Services
- Expanded CPT codes for Telemedicine
- Provider definitions for Physician and Non-physician services
- Physicians at Teaching Hospitals

- 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.

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.
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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.

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.

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)

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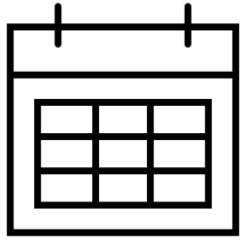
Check with other payers as their policies will likely change in accordance with CMS (this updated changed the effective date from 3/6/2020 back to 3/1/2020)

How long does a PHE declaration last?



- A PHE declaration lasts until the Secretary declares that the PHE no longer exists or upon the expiration of the 90-day period beginning on the date the Secretary declared a PHE exists, whichever occurs first.
- The Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist, and may terminate the declaration whenever he determines that the PHE has ceased to exist.

- The current PHE rules began March 1, 2020. The 90 day period will expire on June 30, 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

Covered Health Care Provider Privacy Protection

- Providers that seek additional privacy protection for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into a HIPAA business Associate Agreement (BAA)
- Examples: Skype for Business, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet

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.
- When providing telehealth across State lines, check with your State Department of Health, and your malpractice carrier

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.
- ND's can bill for any CPT codes that fit the reason and extent of the service. The difference for ND's is that they are not enrolled as Medicare Providers.

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.

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.
- For earlier claims billed with POS 02, contact carriers to ask how to correct claims

Billing with Modifier CS

- For services furnished on March 18, 2020, and through the end of the PHE, outpatient providers, physicians, and other providers and suppliers that bill Medicare for Part B services under these payment systems should use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and should NOT charge Medicare patients any co-insurance and/or deductible amounts for those services.
- ***For professional claims, physicians and practitioners who did not initially submit claims with the CS modifier must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the CS modifier to get 100% payment.***
- For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the CS modifier must resubmit applicable claims submitted on or after 3/18/2020, with the CS modifier to visit lines to get 100% payment.

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***

Monthly 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.
- April 30, 2020 CMS expanded coverage to include Group Psychotherapy, PT, OT, Speech therapy, Radiation Therapy

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.
  - (this is a "live" service)
- An e-visit is when a beneficiary communicates with their doctors through online patient portals.
  - (back and forth via written communication)

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 and other non-physician providers) 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

Increased Payment Rates

CPT EM / Phone	2020 wRVU	National non-facility payment	National facility payment
99211	0.18	$23.43	$9.37
99212 / 99441	0.48	$46.13	$26.31
99213 / 99442	0.97	$76.04	$52.26
99214 / 99443	1.50	$110.28	$80.37
99215	2.11	$148.12	$113.53
98966	0.25	$14.44	$13.35
98967	0.50	$28.15	$26.71
98968	0.75	$41.14	$39.70

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** **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 99422 99423 **G0261** **G0262** **G0263**	Communication between a patient and their provider through an online portal (based on cumulative time spent over 7 day period)
Telephone only	99441 99442 99443 98966 98967 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**

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 under the PHE

- CMS is using different time thresholds for selecting 99201–99215 based on time during the public health emergency.
- Document the total face-to-face and non-face-to-face for all activities by the billing practitioner related to the visit.
- This does not include support staff (nurse) doing pre-visit planning.

Time Increments

Code	CPT Typical Time	CMS
99201	10	17
99202	20	22
99203	30	29
99204	45	45
99205	60	67
99212	10	16
99213	15	23
99214	25	40
99215	40	55

TIME

- CMS is allowing on an interim basis that we apply these rules to office/outpatient visits performed via telehealth during the time of the public health emergency. Specifically, they are removing any requirement for history and/or physical exam.
- A clinician can use **MDM** or **time** to select the code, with time defined as "*all of the time associated with the E/M on the day of the encounter*."
- They are using the existing time guidelines. They are keeping the current definitions of MDM, not the revised set that will be implemented in 2021.

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

- Blue Cross Blue Shield Coronavirus Updates
- Molina Healthcare COVID-19
- Humana Patient Responsibility
- Medicare Coverage of Services
- Cigna Coronavirus Resource Center
- Aetna Provider Resources
- UnitedHealthcare COVID-19 Resources
- UnitedHealthcare Billing Scenarios

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.

AMA Resources

Updated April 3, 2020

Scenario 9: (COVID-19 or Non-COVID-19 case): Telehealth / Telephone visit

Action	Patient evaluated via: E/M Telehealth, Telephone Visit			
Who is performing	Physician / QHP			
Applicable CPT Code(s)	E/M Telehealth [1,2]			Telephone Visit New and Established Patients
	New Patient			99441 (5-10 min) 99442 (11-20 min) 99443 (21-30 min)
		CPT Typical Time	*CMS Typical Time*[4]	
	99201 99202 99203 99204 99205	10 min 20 min 30 min 45 min 60 min	17 min 22 min 29 min 45 min 67 min	
	Established Patient			
		CPT Typical Time	*CMS Typical Time*[4]	
	99212 99213 99214 99215	10 min 15 min 25 min 40 min	16 min 23 min 40 min 55 min	
Applicable ICD-10 CM codes	Non-COVID-19 patient: Code applicable diagnoses COVID-19 patient: Code applicable diagnoses, *add U07.1, COVID-19 (Effective April 1, 2020 -* CDC Announcement)			
Place of Service	11 Physician Office or other applicable site of the practitioner's normal office location			
Notes	1 CMS requires use of modifier 95 for telehealth services; other payors may require its use 2 Individual states (through Executive Order) or payors may permit use of E/M codes with audio-only encounters. 3 CMS will permit reporting of telehealth E/M office or other outpatient visits based on time or Medical Decision Making (MDM) 4 CMS will allow telehealth office visits to be selected and documented based on total time on date of visit via CMS total time			

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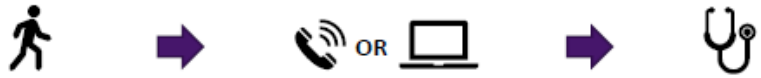
Scenario 8 – (COVID-19 or Non-COVID-19 case): Patient receives virtual check-in OR on-line visits via patient portal/e-mail (not related to E/M visit) OR telephone call from qualified nonphysician (those who may not report E/M)



Action	Communication method	Patient evaluated	
Who is performing		Physician / QHP	Qualified nonphysician (may not report E/M)
Applicable CPT Code(s)	Virtual Check-Ins Telephone	G2010 Remote Image G2012 Virtual Check-In	98966 (5-10 min) 98967 (11-20 min) 98968 (21-30 min)
	Online Visits (eg EHR portal, secure email; allowed digital communication)	99421 (5-10 min) 99422 (11-20 min) 99423 (21 or more min)	98970/G2061 (5-10 min) 98971/G2062 (11-20 min) 98972/G2063 (21 or more min)
Applicable ICD-10 CM codes		Non-COVID-19 patient: Code applicable diagnoses COVID-19 patient: Code applicable diagnoses, *add U07.1, COVID-19 (Effective April 1, 2020* - CDC Announcement)	
Place of Service		11 Physician Office or other applicable site of the practitioner's normal office location	
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			

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Scenario 9: (COVID-19 or Non-COVID-19 case): Telehealth / Telephone visit

Action	Patient evaluated via: E/M Telehealth, Telephone Visit			
Who is performing	Physician / QHP			
Applicable CPT Code(s)	E/M Telehealth [1 2]			Telephone Visit New and Established Patients
	New Patient			99441 (5-10 min) 99442 (11-20 min) 99443 (21-30 min)
		CPT Typical Time	*CMS Typical Time[4]*	
	99201 99202 99203 99204 99205	10 min 20 min 30 min 45 min 60 min	17 min 22 min 29 min 45 min 67 min	
	Established Patient			
		CPT Typical Time	*CMS Typical Time[4]*	
	99212 99213 99214 99215	10 min 15 min 25 min 40 min	16 min 23 min 40 min 55 min	
Applicable ICD-10 CM codes	Non-COVID-19 patient: Code applicable diagnoses COVID-19 patient: Code applicable diagnoses, *add U07.1, COVID-19 (Effective April 1, 2020 -* CDC Announcement)			
Place of Service	11 Physician Office or other applicable site of the practitioner's normal office location			
Notes	1 CMS requires use of modifier 95 for telehealth services; other payors may require its use 2 Individual states (through Executive Order) or payors may permit use of E/M codes with audio-only encounters. 3 CMS will permit reporting of telehealth E/M office or other outpatient visits based on time or Medical Decision Making (MDM) 4 CMS will allow telehealth office visits to be selected and documented based on total time on date of visit via CMS total time			

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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/2020-04/covid-19-coding-advice.pdf

Appendix

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

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.