ENOS Medical Coding

Enos Medical Coding has been working closely with MGMA and payers to bring timely and accurate education to providers during the COVID-19 Emergency.

Practices using Telemedicine codes and portals to communicate with their patients can now take advantage of the Outpatient Evaluation and Management codes, and level of reimbursement, as a result of the waivers issues by HHS Secretary Azar on March 17, 2020. CMS also issued updated, expanded guidance on March 30, 2020. Learn how to document and code under the rules allowed under this new legislation. Understanding the documentation requirements is essential to capturing increased revenue for your practice.

"Telemedicine During the COVID-19 Emergency" ***is a one-hour webinar. Enos Medical Coding is available to schedule with your practice. We offer flexible times, such as evenings or week-ends, to provide this easy to understand webinar to your group. Individuals can sign up on our website to join scheduled webinars next week. We are also available to provide onsite education to your practice as requested. www.enosmedicalcoding.com***

Frequently Asked Questions about Documentation, Coding and Billing under the COVID-19 provisions

1. Q: When can I start billing patients for telemedicine under the new rules?

   A: The rules, announced on March 17, 2020 are retroactive to services provided on or after March 1, 2020. (changed from March 6, to March 1, with the expansion waivers from CMS.)

2. Q: If the patient is not in a rural area, and not in a qualified "originating site" can we bill for telemedicine?

   A: Yes, patients can be located in their own homes, or anywhere else, as long as the telemedicine encounter qualified with the rest of the provisions.

3. Q: I understand that Telemedicine is only covered when the provider is using synchronous telemedicine platform via a Real-Time Interactive Audio and Video Telecommunications System. If our practice does not have that technology, or a vendor, can we bill?

   A: 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)

4. Q: What about HIPAA? My understanding is that the patient must sign an informed consent form for their visit. Is that true?

   A: Under the rules released on Tuesday March 17, 2020 by HHS the HIPAA requirements are not enforced. So, no it's not necessary. The regulation is found here

5. Q: Our organization has privacy restrictions and concerns about the use of provider's cell phones. Will there be exceptions to the HIPAA rules if we allow cell phones?

A: 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.

6. Q: Who can provide Telehealth under the COVID-19 waivers?

   A: 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. Physical therapists 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) 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

   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

   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

7. Q: Do you know if we are allowed to serve patients across state lines (ie in states we are not licensed) at this point?

   A: Check with each state Department of Health. Always check with your Malpractice carrier, also. In most cases, the state will allow individuals in the healthcare field who hold licenses in other states, who have an inactive license, or who have allowed their license to expire in Colorado to immediately resume work within their scope of practice, provided their out-of-state, inactive or expired license is/was in good standing.

   These measures will bolster the workforce's ability to test, treat and care for patients amid this growing crisis by augmenting the number of qualified professionals while creating the ability to backfill positions, as necessary.

8. Should ask commercial insurance companies to find out if they are following the CMS COVID-19 telemedicine guidelines? How do we get this in writing?

A: Many payers are quickly issuing provider bulletins with their written instructions. If you do not get a notification, check payer websites and provider portals

9. Q: Do these rules apply to Medicaid as well?
   A: Medicaid policies vary by State.

10. Q: Do we know there will be reimbursement for telephone calls from private payers?

    A: Commercial and private payers, such as Blue Cross, will advise contracted providers on their policies. On March 30, 2020 CMS included 99441-99443 and 98966-98968 as allowed by CMS for payment.

11. If doing a new patient visit via telehealth, are only 99201-99203 allowed?

    A: CPT 99201-99205 are on the Medicare Telehealth list. However, some payers are restricting the level of service to lower codes.

12. Q: Our staff is doing triage on all calls before deciding if a provider needs to speak to the patient to do a remote visit. Who can bill for telemedicine under the COVID-19 rules?

    A: 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. Nurses and medical assistants are not recognized providers.

13. Q: What CPT codes can be billed for telehealth?

    A: Reimbursement will be allowed for any telehealth covered CPT code **even if unrelated** to treatment of a COVID-19 diagnosis, screen or treatment. There are 181 CPT codes designated as eligible for telehealth payment. (80 codes added 3/31/2020)

    Office or other outpatient visits
    Subsequent hospital and nursing facility care visits
    Psychotherapy
    Health and behavioral assessment and interventions
    End-stage renal disease services
    Emergency Department Visits 99281-99285
    Observation Discharge 99217
    Initial Observation Care 99218-99220
    Subsequent Observation care 99224-99226
    Same day Admission/Discharge 99234-99236
    Initial Inpatient care 99221-99223
    Hospital discharge Management 99238-99239
    Initial Nursing Facility visits and discharge 99305-6
    Nursing Facility Discharge 99315-99316
    Critical Care 99291-99292
    Domiciliary, Rest Home or Custodial Care

New 99327-99328
Established 99334-99337
Home visits New patient 99341-99345
Home visits Established patient 99347-99350
Inpatient Neonatal and Pediatric critical care
Initial 99468 99471 and 99475 (based on age)
Subsequent 99469,99472 and 99476 (based on age)
NICU 99477-99480 based on body weight
99486 Cognitive Assessment
90853 Group Psychotherapy
90952 – 90962 End-Stage Renal Disease
96130-96139 Psychological or neuropsychological test

14. Q: What about preventative codes? Are these allowed for telehealth?

    A: No, because there is very little required for history, and no medical decision making. The physical examination portion cannot be completed remotely.

15. Q: I am understanding that we can have new patient visits via telemedicine during this time? Regardless of state?

    A: The requirement for a patient to be established, and seen withing the last 3 years, is not being enforced for the duration of COVID-19. The expanded rule issued 3/30/2020 included new and established patients.

16. 11. What about time-based coding for new patient visits?

    A: I recommend time as a basis for new patient codes as you cannot perform and "score" and exam.

17. Q: What diagnosis code should be reported?

    A: 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.

18. Q: What diagnosis code should I report if the telemedicine "visit" is COVID-19 related?

    A: 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) (effective 4/1/2020)

-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

19. Z71.84 seems to always get denied.

A: we recognize that correct coding does not guarantee payment. Try to appeal due to the current COVID-19 circumstances. If possible, list signs and symptoms first, followed by status codes.

20. Q: Can Telemedicine visits be billed for new patients to our practice?

A: The new rules do not enforce the established relationship requirement that a patient see 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.

21. Q: We have a patient portal, can we bill for communicating with patients via the portal?

A: 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.

Report **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.

There are restrictions. 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.

1. Does the telemedicine visit have to be with a visual contact, or can it be just via phone?

A: The patient and provider must use audio and video for contact. Phone alone is insufficient for E/M.

22. Q: How can I bill for telephone calls by a physician without video capability?

    A: **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***

    99442 … 11-20 minutes of medical discussion

    99443 … 21-30 minutes of medical discussion

23. Q: How do I bill for a nonphysician telephone call without video capability?

    A: For telephone calls by a qualified nonphysician (licensed health care professional)

    98966 Telephone assessment and management service provided by a qualified nonphysician health care professional 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***

    98967 … 11-20 minutes of medical discussion

    98968 … 21-30 minutes of discussion

24. Q: What place of service should be on my claim?

    A: For Medicare telehealth services, the claim should reflect the designated Place of Service that reflects the service type (11 for office, 21 for inpatient hospital, etc) As of 3/30/2020, add Modifier 95 to your HCPCS codes to indicate the billed service was furnished as a professional telehealth service from a distant site.

25. Since we are reporting an E/M Code, how do we choose the level of service?

    A: Each visit should be supported by documentation, such as a SOAP note. The History should be taken by interviewing the patient and writing a History of Present Illness (HPI) and Review of Systems (ROS). Other Past, Family or Social history, as necessary, should be documented. The physical exam will not be possible beyond a statement of the patient's general appearance. The Medical Decision Making (MDM) should state the diagnosis or symptoms, tests ordered/reviewed and the level of risk based on treatment plan. Time can also be considered, if documented. The Level of Service can be based on either History and Medical Decision Making, or Time, whichever is more advantageous to the provider.

26. 19. Can we chart physical exam numbers given to us by the patient (ie: they weighed themselves at home, or took their own blood pressure)?

    A: Yes, reliable, simple at home measurements provided by the patient can be recorded. Some patients take their blood pressure or pulse oximetry using simple equipment at home. Note in your chart that it was self- reported.

27. For OBJECTIVE, does it make sense to document patient appearance, psych, voice, etc. things that can be seen, heard? Is it helpful at all to document in OBJECTIVE section, any notes on "patient sounds to not be in distress"? Or patient is alert and oriented?

    A: Only document what you can objectively confirm. Use your own clinical judgement and observations.

28. Can we use prolong service code, 99354, 99355 for prolong phone call E/M codes?

    A: Prolonged service codes are on the list of covered services. They do not require any modifier.

29. Q: Since we will be reporting outpatient E/M codes will the patient be responsible for paying a copay?

    A: Yes, but 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.

30. 20. Since copays are being waived for visits pertaining to diagnosed COVID19, would you recommend for patients presenting with potential COVID-19 in the differential to defer copay collection until after results are confirmed/ruled out & bill them for the copy after the fact?

    A: You do not have to waive copays at all. If you do choose to waive a copay it will not be a problem.

    Payers such as Cigna, Humana, Blue Cross/Blue Shield and United Healthcare have waived COVID-19 related copays and deductibles.