CODING and BILLING GUIDANCE DURING COVID-19 PUBLIC HEALTH EMERGENCY
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THREE TYPES OF VIRTUAL VISITS per CMS
Source: Medicare

1. **Telehealth** – Must include audio AND video communication

2. **Virtual Check-**Ins
   A. Brief (5-10 minutes) check-in with patient's practitioner via telephone or other telecommunication device to decide whether an office visit or other service is needed
   B. A remote evaluation of recorded video and/or images submitted by an established patient

3. **E-Visits** – A communication between a patient and their provider through an online patient portal.

Effective March 6, 2020, provisions under the 1135 waiver apply to Medicare covered services.

TELEHEALTH

Click here for a list of CMS covered telehealth services.

Patient location – Includes a patient's home. A distant site provider may also bill for covered telehealth services provided in locations that were previously covered.

Provider/patient relationship – The Department of Health and Humans Services (HHS) announced a policy of enforcement discretion for Medicare telehealth services. To the extent the 1135 waiver requires an established relationship with a practitioner, HHS will not conduct audits to ensure such a relationship exists for claims submitted during the COVID-19 public health emergency (PHE).

Required technology - Telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication (Synchronous)
-The 1135 waiver allows the Secretary to authorize use of telephones that have audio and video capabilities for furnishing Medicare telehealth services during the COVID-19 PHE.
- HHS Office of Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through technologies such as FaceTime or Skype during the COVID-19 PHE.

Consent – Required

The TMA Legal Department created a consent for to use with telemedicine patients. To request a copy, email legal@tnmed.org.

Billing
- Use the CPT or HCPCS code to describe the service provided (must be a service listed on the CMS list of covered telehealth services). This list is for **"traditional"** covered telehealth services.

- The Department of Health and Humans Services has issued an Interim Final Rule with Comment Period, that instructs 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. Because they currently use the POS code on the claim to identify Medicare telehealth services, they are finalizing **on an interim basis** the use of the CPT telehealth modifier 95. Modifier 95 should be applied to claim lines that describe services furnished via telehealth. HHS maintains the facility payment rate, which is significantly less, for services billed using the general telehealth POS code 02 should physicians choose to maintain their current telehealth billing practices.

Here is a list of "**non-traditional"** services that have been approved for telehealth during the PHE. Visits should be billed with POS as if it were an in-person encounter and a 95 modifier:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475- 99476) Initial and Continuing Intensive Care Services (CPT code 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Radiation Treatment Management Services (CPT codes 77427)
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

- Submit Medicare claims to the Medicare Administrative Contractor (MAC) that processes claims for the performing physician/practitioner's service area (Palmetto for Tennessee)

Consistent with current rules, G0 modifier is required for telehealth service related to diagnosis and treatment of an acute stroke. GT modifier **is not used** for Medicare Part B.

Cost-sharing flexibilities – Use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visit paid by federal healthcare programs.

VIRTUAL CHECK-INS

G2012 – Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified healthcare 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

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 procedure within the next 24 hours or soonest available appointment

Clinicians can provide virtual check-in services to both **new and established** patients.

A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients:

CPT codes 98966-98968 – Non-Face-to-Face Telephone Non-physician Services provided by a qualified healthcare professional to a patient and must not end with a decision to see the patient within 24 hours or the next available urgent visit appointment.

99441-99443 – Non-Face-to-Face Telephone Services provided by a physician or other qualified healthcare professional and must not end with a decision to see the patient within 24 hours or the next available urgent visit appointment.

On April 30, CMS announced it was increasing payment for 99441-99443 to "match payments for similar office and outpatient visits." This will increase payments for these services from a range of approximately $14-$41 to approximately $46-$110. The payments are retroactive to March 1, 2020. Palmetto will not reprocess retroactively; however, you can resubmit claims for dates of service between March 1st and April 30th and receive the increased payment amount. Claims submitted after April 30, 2020 should be paid at the increased rate.

See individual payer resources below for commercial payer coverage.

Virtual check-ins can be conducted with broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

Practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Co-insurance and deductible would generally apply to these services.

Consent required – Contact TMA legal department at legal@tnmed.org to request a consent form.

VIRTUAL CHECK-INS CAN ONLY BE REPORTED BY PHYSICIANS AND OTHER QUALIFIED HEALTH PROFESSIONALS THAT HAVE BILLING PRIVILEGES. COMMUNICATION WITH CLINICAL STAFF, SUCH AS NURSE OR MEDICAL ASSISTANT TRIAGE, IS NOT A BILLABLE SERVICE.

E-VISITS

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
99422- 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 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

Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits utilizing the following HCPCS codes:

G2061 - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
G2062 - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
G2063 - Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

- May only be reported when the billing practitioner has an established relationship with the patient; however, under the 1135 waiver, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during the public health emergency.
- Not limited to certain locations
- Medicare Part B reimburses for E-visits, **patient initiated** online evaluation and management visits, **conducted via a patient portal**
- Co-insurance and deductibles would generally apply to these services
- Consent required (Most EMR systems already have consent requirements for portal use)

REMOTE PATIENT MONITORING

Clinicians can provide remote patient monitoring services to both **new and established patients**. These services can be provided for both acute and chronic conditions and can now be provided for patients

with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473- 99474, 99493-99494)

DIAGNOSIS CODES

For cases where there is a concern about a **possible exposure** to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.

For cases where there is an **actual exposure** to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

For confirmed cases of COVID, assign **U07.1,** 2019-nCoV acute respiratory disease - Effective April 1, 2020.

LABORATORY CODES

The CPT Editorial Panel approved a new Category I Pathology and Laboratory code for novel coronavirus testing. This code is effective March 13, 2020.

87635 Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19], amplified probe technique

This is an early release code, so you will need to manually upload this code descriptor into your electronic health record system. For further information, see CDC Coding Guidelines.

MODIFIERS

95 –Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
GT – via an interactive audio and video telecommunications system
GQ – Via an asynchronous communications system
G0 - Telehealth services for diagnosis, evaluation or treatment of symptoms of an acute stroke

- Aetna – No modifiers except on behavioral health – POS 02
- Amerigroup – GT or 95 modifier – POS same as in-person **OR** POS 02
- Blue Cross Blue Shield –POS same as in-person visit with 95 modifier **OR** POS 02
- Cigna – GQ, GT, or 95 - POS code same as in-person visit
- Humana – Follows CMS guidelines
- Palmetto – Modifier 95 – (G0 for acute stroke) - POS same as in-person visit
- United Healthcare – GQ, GT or 95 – POS same as in person **OR** POS 02

See additional resources below for individual payers

DOCUMENTATION GUIDELINES

Documentation guidelines have not changed. You still have to document your encounters to bill for your services. Remember, medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.

It is imperative to document the mode of the visit such as audio/visual encounter, telephone encounter, etc. Payers are not auditing during the PHE; however, they will be auditing once the PHE is over and those audits will include services performed during the PHE.

HHS has released an Interim Final Rule with Comment Period that includes documentation relaxation during the COVID-19 PHE. This guidance allows providers to use Medical Decision Making (MDM) or Time as the defining factor in selecting the appropriate level of service for office/outpatient, E/M only telehealth encounters. This relaxation is already planned to be implemented January 1, 2021; however, they are allowing this portion of the rule during the PHE.

"On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule."

CAUTION: Recommend including HPI in documentation to prove medical necessity

MISCELLANEOUS INFORMATION
- HIPAA relaxation rule only applies to the use of technology. Must continue to follow all other HIPAA rules.
- ERISA plans may not offer telehealth benefits.
- Do not file United Healthcare telehealth claims until April 1st or Cigna and Palmetto telehealth claims until April 6th. Claims filed before this time will be denied due to system edits. All other payers are currently accepting telehealth claims.
- Keep in mind, the relaxation of rules and guidelines is TEMPORARY
- Beware of effective dates

INDIVIDUAL PAYER BILLING GUIDELINES

Aetna billing and coding guidelines

Amerigroup COVID-19 updates

Blue Cross COVID-19 updates

Cigna billing and coding guidelines

Humana billing and coding guidelines

Palmetto latest articles

TriWest telehealth quick reference guide

United Healthcare billing and coding guidelines