This correspondence and discussion of this issue should not be construed as legal advice or representation by the TMA. It does not constitute an attorney-client relationship between you or any TMA employee. This unwarranted material is provided only for informational purposes. Should you require legal advice or representation, you should contact your personal attorney.
OBJECTIVES

- Define Telehealth, Virtual Visits, and E-Visits per CMS guidelines
- Understand what technology is allowed to perform Telehealth services
- Determine which procedure and diagnosis codes are allowed for reimbursement
- Appropriate documentation to support a Telehealth visit
Per CMS – Three Types of Virtual Visits:

1. **Telehealth** – MUST include audio and video communication

2. **Virtual Check-ins**
   - 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
   - A remote evaluation of recorded video and/or images submitted by an established patient

3. **E-visits** – A communication between a patient and his/her provider through an on-line patient portal

**SOURCE:** https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
Effective March 6, 2020, provision under 1135 waiver applies to Medicare covered services.

### LIST OF MEDICARE TELEHEALTH SERVICES

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### LIST OF MEDICARE TELEHEALTH SERVICES

For a list of “traditional” CMS covered Telehealth Services, visit:

[https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes](https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes)
Telehealth Coverage and Changes

• Consent is REQUIRED
  – Must have a Telehealth consent on file or verbal consent in documentation

• Patient Location
  – Includes a patient’s home during public health emergency
  – Distant site provider may also bill for telehealth services in locations that were previously covered

• Provider/Patient relationship
  – Relaxed the requirement for provider/patient relationship during the public health emergency
Required Technology – Telecommunications technology that has 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 public health emergency.

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 public health emergency.
Virtual Visits – Billing and Coding

• 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 is for “traditional” telehealth services.

• Distant site providers use Place of Service (POS) 02 – Telehealth

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

• Medicare pays the facility rate on all services billed with POS 02
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.
Per CMS notification received March 31, 2020, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for “non-traditional” telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. As a reminder, CMS is not requiring the “CR” modifier on telehealth services. Medicare reimburses the same amount for non-traditional telehealth services as it would if the service were furnished in person.
Virtual Visits – Billing and Coding

CMS LIST OF ADDED NON-TRADITIONAL TELEHEALTH CODES

- 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)

Continued on next slide.....
Virtual Visits – Billing and Coding

- 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.
Virtual Check-Ins

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.

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
Virtual Check-Ins

• 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.
Virtual Check-Ins

- Virtual check-ins can be conducted with a broader range of communication methods.

- 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

- See individual payer resources for commercial payer coverage.
E-Visits

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.

- **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
E-Visits

- 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)
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
New CPT® Code

Most recently, 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.
CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2.

The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19).

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

For further information, see the CDC Coronavirus coding supplement
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
  - Modifier use varies with commercial payers
Documentation guidelines have not changed. You still have to document your encounters in order 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.
“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.”

***RECOMMEND INCLUDING HPI TO SUPPORT MEDICAL NECESSITY***

Questions To Ask Payers

- What services are covered?

- What are the effective dates?
  (Most insurers are limiting this exemption to a specific period of time)

- May these services be provided by Nurse Practitioners, Physician Assistants, and other Qualified Healthcare Providers (QHP)?

- How are services to be billed?
  - Do we use telehealth codes or office visit codes?
  - What place of service?
  - What modifiers are necessary?
Carrier Tidbits

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

See additional resources for individual payers
FILING DATES for TELEHEALTH VISITS

- CIGNA and Palmetto – April 6, 2020
- United Healthcare – April 1, 2020

Claims filed prior to these dates may be denied due to payer edits
Individual Payer Billing Guidelines

Aetna
https://www.aetna.com/health-care-professionals/provider-education-manuals/covid-faq.html#acc_link_content_section_responsivegrid_copy_responsivegrid_accordion_10

Amerigroup

Blue Cross
https://bcbstupdates.com/
Individual Payer Billing Guidelines

Cigna

Humana
https://www.humana.com/provider/coronavirus/telemedicine

Palmetto

United Healthcare
QUESTIONS
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