Telemedicine and COVID-19:

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

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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-9and 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

- Telemedicine Codes Overview
- Waivers under Section **1135** waiver requests for CMS
- Documenting E/M for Remote Visits
- Telehealth Modifiers
- Diagnosis Coding

- 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 Telemedicine?

- Telemedicine is the practice of medicine using technology to deliver care at a distance. A physician in one location uses a telecommunications infrastructure to deliver care to a patient at a distant site.
- The service must be patient initiated.
- As long as the physician performs and documents the elements of history, exam and decision making (or time counseling) and document them the same as you would in person – and meet the conditions of a telemedicine visit- then you can bill and E/M visit.

Medicare Requirements

- Medicare requires the GT modifier and
- The patient must be in a HPSA (healthcare professional shortage area)
- Medicaid may or may not pay
- Most commercial insurance accepts the 95 modifier

Telemedicine Codes

- The **codes** 99201-99205, 99211 - 99215, the consultation **codes** 99241-9945 and others can be reported with the **telemedicine** modifiers QT or 95 depending on the payer.
- The American Academy of Family Physicians has an article on their website that discusses Telemedicine Reimbursement and Licensure
- https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/BKG-Telemedicine.pdf

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 or other qualified healthcare professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.
- The totality of the communication of information exchanged between the physician or other qualified healthcare professional and patient during the course of the synchronous telemedicine service 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.

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 6, 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.
- Check with other payers as their policies will likely change in accordance with CMS.

Geographic Restrictions

- Patients can receive telehealth services in non-rural areas
- Under the “normal” rules,
  - a patient must be located in a rural area
  - The patient must be at a “qualified originating site” such as a hospital or healthcare facility
  - The visit is conducted by the facility with the performing physician in another location

Available to Patients in Their Homes

The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are ***in their homes*** or any setting of care.

Waiving Communication Restrictions

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.

Real-Time Communication

- The provider must use an ***interactive*** audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- Both the provider and the patient must be able to communicate using audio and video. (***E.g. Facetime***).
- Under this HHS 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.

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

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 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.

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.

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.
- 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***

Billing for Telehealth Services

- Medicare telehealth services are generally billed as if the service had been furnished in-person.
- For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Billing for Telehealth Services

- Medicare pays the same amount for telehealth services as it would if the service were furnished in person.
- For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the ***facility*** payment rate when services are furnished via telehealth.

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.

Patient Status

- 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.

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.

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 ($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.

How is Telehealth 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 **place of service 02** to indicate the service was performed via telehealth.
- An e-visit is when a beneficiary communicates with their doctors through online patient portals.

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

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

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	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 a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	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	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 recroded video and/or images submitted by an establish patient.	HCPCS code G2012 HPCPS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal	99421 99422 99423 G2061 G2062 G2063	For established patients.

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

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

Documentation Requirements for Telehealth

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

History

Past, Family and/or Social History (PFSH)

– **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

A **Presenting Problems to the Treating Provider** (# Diags Require Active Management **or Affect Treatment Options**)	Points	= Result	
Self limited / minor (stable, improved or worse)	Max = 2	1	
Est. problem (stable, improved)		1	
Est. problem (worsening)		2	
New problem (to Provider) (no add'l workup)	Max=1	3	
New problem (to Provider) (additional workup)		4	
Bring total to Line A in Final Result for Complexity **TOTAL**			

New vs. Self limited problem: If the problem warrants the initiation of a new treatment plan *(ie: prescription drug management, additional diagnostic workup, referral to a specialist, over the counter medications with provider follow up if needed, etc),* it's new. If the problem does not warrant the creation of a treatment plan, it's self limited/minor.

Medical Decision Making

B	Amount **and/or** Complexity of Data to be Reviewed	**Pts.**
	Review or order of clinical lab tests	1
	Review or order of tests in the radiology section of CPT	1
	Review or order of tests in the medicine section of CPT	1
	Discussion of test results with performing physician	1
	Decide **to obtain** old records or **to obtain** history from someone else	1
	Review & summarize old records **or get Hx** from someone **or** talk with **other provider**	2
	Independent visualization of image, tracing or specimen itself (not simply review of the paper copy report)	2
	Bring total to Line B in Final Result for Complexity **TOTAL**	

Level	Presenting Problem(s)	Management Options Selected
Minimal	• One self-limited or minor problem (cold, insect bite, tinea corporis) [i.e. runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status]	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (well controlled hypertension, stable diabetes, cataract, BPH) • Acute uncomplicated illness or injury (cystitis, allergic rhinitis, simple sprain)	• Over the counter drugs, or renewal of long-term medications, w/o history of adverse side effects • Minor surgery w/ no identified risk factors • Physical therapy • Occupational therapy • IV fluids w/o additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (lump in the breast) • Acute illness with systemic symptoms (pyelonephritis, pneumonitis, colitis) • Acute complicated injury (head injury w/ brief loss of consciousness)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management such as writing a new script, renewing recently prescribed drugs, adjusting dosages, or discontinuing medications • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation w/o manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illness or injury that may pose a threat to life or bodily function (multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure, etc) • An abrupt change in neurologic status (seizure, TIA, weakness, sensory loss)	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factor • Emergency major surgery • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

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**

Counseling and/or Coordination of Care

- Whenever counseling and/or coordination of care dominates (more than 50% of) the encounter, time is considered the ***key or controlling factor*** to qualify for a particular level of E/M service.
- 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

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.***"
- This is in line with the 2021 changes to E/M level selection for office visits, where the time may be used for level section, and the time includes the total time on the date of the encounter and includes face-to-face and non-face-to-face time spent personally by the provider.

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

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.

Telehealth Modifiers

- Check with payers to verify their requirements for modifiers

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.

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 October 1, 2020**

Key Takeaways

- 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 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 6, 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.

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.

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