Covid-19 and Telemedicine

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There seems to be a lot of confusion on how to bill telemedicine services. The information in this article is current as of 4/9/2020. Physicians should review any additional information published by CMS and other health plans for the most up-to-date information.

This article will cover the different types of telemedicine services covered by Medicare.

- Telehealth
- Telephone calls
- E-Visits - On-line services

When selecting a code based on time, documentation must clearly reflect the time spent providing the service.

These services are considered "physician work." Physicians should not report the services when provided or partially provided by a technician. For these services, front office staff and technicians can perform the following

- Initial contact with the patient
- Obtain patient's telephone number
- Explain telemedicine services being offered and obtain and document the patient's verbal consent
- Confirm insurance coverage – Contact insurer to determine which telemedicine services are covered and patient's financial responsibility
- Provide the patient information on when the physician will be contacting the patient based on which telemedicine service option is pertinent to the patient

The American Academy of Ophthalmology (AAO) information regarding telehealth and telephone calls is posted at https://www.aao.org/practice-management/news-detail/coding-phone-calls-internet-telehealth-consult. This information is frequently updated. We recommend viewing the on-line presentations available on the AAO's website.

Families First Coronavirus Response Act Waives Coinsurance and Deductibles for Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:

- Office and other outpatient services
- Hospital observation services
- Emergency department services
- Nursing facility services
- Domiciliary, rest home, or custodial care services
- Home services
- Online digital evaluation and management services

Cost-sharing does not apply to the above medical visit services for which payment is made to:

- Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
- Physicians and other professionals under the Physician Fee Schedule
- Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Federally Qualified Health Centers (FQHCs)

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.

Additional CMS actions in response to COVID-19, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19, visit www.coronavirus.gov. For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Telehealth

For Original Medicare, the physician must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. §410.78(a)(3) states that telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications systems for purposes of Medicare telehealth services.

Effective March 6, 2020, on an interim basis during the public health emergency (PHE) for the COVID–19 pandemic, CMS specified 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 removes any requirements regarding documentation of history and/or physical exam in the medical record. When reporting by time, physicians should use the 2021 times associated with the office/outpatient E/M codes.

- 99201 – 1-14 minutes
- 99202 – 15-29 minutes
- 99203 – 30-44 minutes
- 99204 – 45-59 minutes
- 99205 – 60-74 minutes
- 99212 – 10-19 minutes
- 99213 – 20-29 minutes
- 99214 – 30-39 minutes
- 99215 – 40-54 minutes

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.

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.

Please remember that you must explain to the patient they will be charged for the non-face-to-face encounter and obtain their verbal permission to perform the service. This information must be documented in the medical record.

Although the rule was posted on 3/30/2020, it was not published in the Federal Register until April 6, 2020.

To bill for telehealth services, the physician should

- Report the appropriate office/other outpatient E/M code (99201-99215) that describes the service
- Append modifier -95 to the CPT code
- Per the Interim Final Rule, published April 6, 2020, physicians and practitioners are not to report POS 02 for telehealth services. During the PHE, physicians and practitioners who bill for Medicare telehealth services are instructed to report the POS code that would have been reported had the service been furnished in person. This will allows Medicare to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID–19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.

UnitedHealthcare is waiving the Centers for Medicare and Medicaid's (CMS) originating site restriction and audio-video requirement for Medicare Advantage, Medicaid, and Individual and Group Market health plan members from March 18, 2020 until June 18, 2020. Eligible care providers can bill for telehealth services performed using interactive audio-video **or audio-only**, except in the cases where we have explicitly denoted the need for interactive audio/video, such as with PT/OT/ST, while a patient is at home.

Telephone Calls
During of the PHE for the COVID–19 pandemic, separate payment for telephone E/M services will be made using CPT codes CPT codes 99441–99443 and 98966–98968.

CMS believes it is important during the PHE to extend coverage for these services to both new and established patients. While some of the code descriptors refer to "established patient," during the PHE CMS is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the

code descriptors. Specifically, CMS will not conduct review to consider whether these services were furnished to established patients.

The following elements apply to telephone E/M services:

- Discussion must be initiated by patient, parent, or guardian.
- Document reason for communication, pertinent data reviewed assessment, and plan.
- Not separately billable if related to an E/M service provided within the previous seven days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

Physicians and Qualified Healthcare Professionals report telephone E/M services using the following CPT codes

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 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; 11–20 minutes of medical discussion

99443 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; 21–30 minutes of medical discussion

CPT codes 98966–98968 describe the assessment and management services performed by practitioners who cannot separately bill for E/Ms. CMS notes that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.

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 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; 11–20 minutes of medical discussion

98968 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; 21–30 minutes of medical discussion

E-Visits – On-line Services
An e-visit is when a beneficiary communicates with their doctors through online patient portals.

In all types of locations including the patient's home, and in all areas (not just rural), established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient.

For these **E-Visits**, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible applies to these services.

- The patient must be established to the practice.
- These codes are for the cumulative time spent over seven days.
- Document the time spent in the note.
- Must be unrelated to an E/M service provided within the previous seven days and is not separately billable if it results in a subsequent face-to-face E/M visit within the next seven days.

Physicians and Qualified Healthcare Professionals can bill for E-visits performed by e-mail using the following codes

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

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.