PINNACLE

COVID-19: Telehealth – Visit Billing

Resources and Tip Sheet

As the COVID-19 pandemic and federally declared state of public health emergency evolves, healthcare providers are quickly and desperately looking to telemedicine as a viable alternative to traditional office visits for limiting not only their patients' exposure to each other, but their providers' exposure to patients to ensure compliance with safety and distancing requirements. Increased interest in telemedicine combined with recent changes to situation / circumstances, coverage, documentation and billing guidelines and laws have led to a significant increase in requests for information and education about telehealth reimbursement compliance.

In an effort to provide support with accessible information on demand, we've created a tip sheet for quick reference, supplemented by direct links to the CMS and AMA where these changes continue to develop.

The tip sheet will be updated as new information is released and analyzed.

Have questions? Need assistance? Feel free to contact us directly to schedule a call with one of our billing compliance experts.

We will get through this together. Be considerate and kind. Be well. Stay healthy.

PINNACLE

TIP SHEET

Effective 3/1/2020 & Duration of PHE

As of January 22, 2021, 5pm EST

COVID-19 Technology Assisted Visits

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PURPOSE

As physicians and other qualified healthcare providers plan a response to patient inquiries regarding coronavirus symptoms and concerns, information is emerging from the Centers for Medicare and Medicaid Services ("CMS") as coverage and access to care changes during the COVID-19 outbreak under the 1135 waivers. This document was prepared and evolves as newly released information becomes available. Please note all providers must be responsible for verifying the information contained herein and keep up to date as guidance is updated from official sources, such as the Centers for Disease Control, ("CDC"), American Medical Association ("AMA"), CMS, State Medicaid and other payor & public health websites.

Visits and virtual services are important tools to maintain reasonable patient access with an attempt to keep patients healthy and helping to contain community spread of the COVID-19 virus.

Please note: This guidance is subject to change during the current COVID-19 PHE as additional information is provided by CMS, other Government Agencies and Commercial Payers.

Contact:

Lori Carlin
(303) 801-0111
LCarlin@AskPHC.com

Website Links:

- CMS Newsroom
- AMA – Stay Informed
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VIRTUAL CHECK-IN: HCPCS G2012

Brief communication technology-based service, e.g., virtual check-in, by physician or other qualified health care professional who can report evaluation and management ("E/M") services, provided to an established patient ("pt"), not originating from a related E/M service within previous 7 days nor leading to E/M service or procedure within next 24 hours or soonest available appointment. 5-10 minutes of medical discussion.

Place of Service = provider's place of service code

COVERAGE REQUIREMENTS

- Interim final rule ("IFC") allows new or established patient during public health emergency ("PHE")
- Expected to be patient initiated, but provider may need to provide beneficiaries information on this specific visit availability
- Requires direct phone or telecommunication/technology based between patient & provider
- Brief, approximately 5-10 minutes
- ***Qualified Non Physician Healthcare Providers*** *("QNHP") who can not report E/M services such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists are allowed to report this code. Not for use by clinical staff whose work is included in payment for services when billed by the E/M able billing provider.*
- ***QNHPs*** can bill with modifiers (GO, GP, GN) for est. patient w/ care plan
- **DO NOT BILL IF** this service results in any visit within 24 hours, next available, or visit by the same provider / specialty within previous 7 days
- No setting / location limitation; [wRVU = 0.25]
- Use modifier CS only on visits related to COVID-19 testing

DOCUMENTATION

- Documented Patient Consent [or *by ancillary or provider at least 1x/year]* under GENERAL supervision
- Chief Complaint / Reason for Encounter
- Pertinent History, Exam, Medical Decision Making
- Diagnosis
- Duration of Encounter
- *Suggested notation Justifying technology assisted service delivery:*
  - *Example: Pt presents during COVID-19 pandemic / federally declared state of PHE. Service conducted via (specify telephone or audio/video). Patient is (specify immunocompromised; has co-morbidities posing risk if exposed; exhibiting signs/symptoms /suspicious for COVID-19; diagnosed COVID-19 positive, etc.)"*

ICD-10-CM

- Z20.822 Contact with and (suspected) exposure to COVID-19.
- U07.1 disease diagnosis of COVID-19 confirmed by lab testing **(Effective 4/1/20)**
- Code only confirmed cases- if unconfirmed, identify encounter reason
- **CDC-WHO ICD-10-CM Guidance & WHO - COVID-19 Notice**

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REMOTE EVALUATION OF PATIENT VIDEO/IMAGES: HCPCS 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

Place of Service CMS 1500 = provider's place of service

COVERAGE REQUIREMENTS

- Non-face-to-face patient-initiated service with billable visits within previous year
- Video or images sent to provider or QNHP via (store and forward), patient portal inquiry
- Qualified Non Physician Healthcare Providers ("QNHP") who can not report E/M services such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists are allowed to report this code. Not for use by clinical staff whose work is included in payment for services when billed by the E/M able billing provider.
- QNHPs can bill with modifiers (GO, GP, GN) for est. patient w/care plan
- Providers must provide a response within 24 hours to the inquiry
- Encounter / information received must be stored permanently to report this service.
- Reported once in a 7-day period
- For condition not related to service provided w/in previous 7 days and does not result in service w/in 24 hours or soonest available appointment.
- wRVU= 0.18
- Use modifier CS only on visits related to COVID-19 testing

DOCUMENTATION

- Documented Patient Consent [or *by ancillary or provider at least 1x/year]* under GENERAL supervision
- Chief Complaint / Reason for Encounter
- Interpretation of information received
- Follow up action, impression of information received and treatment decision(s) resulting from the service.
- Diagnosis
- *Suggested notation Justifying technology assisted service delivery:*
  - *Example: Pt presents during COVID-19 pandemic / federally declared state of PHE. Service conducted via (specify telephone or audio/video). Patient is (specify immunocompromised; has co-morbidities posing risk if exposed; exhibiting signs/symptoms /suspicious for COVID-19; diagnosed COVID-19 positive, etc.)"*

ICD-10-CM

- Z20.822 Contact with and (suspected) exposure to COVID-19.
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TELEPHONE E/M OR TELEPHONE A/M

CPT® 99441-99443 (MD) **or** (QNHP) CPT® 98966-98968

Telephone E/M service, for an established patient, telephone or online for up to 7 days, cumulative time during the 7 days…

- 99441 / 98966 of cumulative time during seven-day period is 5-10 min
- 99442 / 98967 for 11 to 20 min;
- 99443 / 98968 for 21 or more min

Place of Service = provider's place of service code

COVERAGE REQUIREMENTS

- IFC allows new or established patient during PHE.
- General Supervision
- Expected to be patient initiated, however provider may need to provide beneficiaries information on this specific visit availability
- Requires direct phone OR online communication between patient and provider
- ***QNHP*** *with modifiers (GO, GP, GN) for est. patient with established care plan*
- No setting or location limitation
- 99441-43: 0.70, 1.30, 1.92 - 98966-68: 0.25, 0.5, 0.75
- Use modifier CS only on visits related to COVID-19 testing

DOCUMENTATION

- Chief Complaint / Reason for Encounter
- Pertinent History, Exam, Medical Decision Making
- Diagnosis
- Duration of Encounter
- *Suggested notation Justifying technology assisted service delivery:*
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ICD-10-CM

- Z20.822 Contact with and (suspected) exposure to COVID-19.
- U07.1 disease diagnosis of COVID-19 confirmed by lab testing **(Effective 4/1/20)**
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AUDIO & VIDEO VISITS (PATIENT & PROVIDER ARE IN DIFFERENT LOCATIONS)

New & Established Pts CPT® 99202-99205, 99212-99215, 99241-99245

CMS added the following or eliminated frequency limits on 3/30/2020 for:
(ED) 9928X, (OBS) 99217-20, 99224-36, (IP) 9922X, 9923X, 99238-39, (CC) 9929X, G0508-G0509, (neo/peds-CC) 99468-80, (SNF) 99304-16, (RH) 99327-28, 99334-37, (Home) 99341-50, (Psych) 90853, 96130-39, (ESRD) 90952-53, 90959, 90962, (Caregiver) 99483 (See CMS Telehealth List for all eligible codes)

- E/M code reported is chosen based on the setting, patient status (new, established, initial, subs, etc…), setting where visit would have been provided if rendered in person & level of care rendered
- Pt and provider are in DIFFERENT LOCATIONS
- Use modifier 95 for telehealth; Modifier CS for visits related to COVID-19 testing
- Office/Outpatient E/M (99202-99205, 99212-99215) level based on MDM or time requirements.
- Other E/M Services (Hospital Observation, Hospital Inpatient, ect.) level based on History, Exam and MDM or time requirements.
- Ancillary staff performing visit services representative of 99211 in a physician office (POS 11) and meeting ALL requirements of 'incident to' a physician's services may bill with the supervising provider's NPI when performance of the service meets criteria for a video visit. Supervision may be satisfied via audio / video and the supervising provider is immediately available to intervene care as necessary / medically appropriate (see CMS; Office hours- 5/14/20)

Place of Service = report the provider's usual place of service code

COVERAGE REQUIREMENTS

- Visits reported the same as if they were rendered traditionally as in person visits
- Require direct real-time audio & video communication between patient & provider/clinician
- Not limited to certain settings or locations, may be provided in any healthcare facility and in patient's home
- General Supervision

DOCUMENTATION

- Best Practice to document Patient Location and Provider location at time of visit but not a requirement, check payer specific guidelines
- Chief Complaint / Reason for Encounter
- Pertinent History, Exam, Medical Decision Making
- Diagnosis
- Duration of Encounter
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ICD-10-CM

- **CDC-WHO ICD-10-CM Guidance & WHO - COVID-19 Notice**
- Assign appropriate diagnosis to support service.
- Verify Medicaid and Commercial rules and requirements, they will vary.

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EVALUATION & MANAGEMENT VISIT (PATIENT & PROVIDER IN THE SAME LOCATION) – W/ TECHNOLOGY ASSISTANCE (THIS IS NOT TELEHEALTH)

CPT® E/M Visits where appropriate and conducive in limiting the exposure, ration PPE and protect healthcare providers rendering pt care visits regarding face-to-face contact and medical appropriate to do so…

- CPT® E/M visits generally by definition require face-to-face interaction. **During the PHE, where the use of technology assists rendering patient care, AND when the provider and patient are in the same location, the service is not considered 'telehealth' according to CMS telehealth policy.**
- Same location is same location reported i.e. same floor, same campus
- During PHE, CMS is allowing visits rendered with the assistance of technology (type not defined, but type used should be medically appropriate based on provider judgement)
- Billed as E/M visits, as if they were performed in a traditional sense even when in person / face-to-face component is not met and where the utilization of technology provides the communication with the patient.
- No modifier is required to differentiate E/M rendered with technology and without a face-to-face physical interaction between the provider and patient (See CMS COVID-19 FAQs; Medicare Telehealth; Q. #9)

Place of Service = location where E/M was provided.

COVERAGE REQUIREMENTS

- Coverage and payment same as traditional E/M visit service delivery
- Visits considered same as traditionally delivered visit

DOCUMENTATION

- E/M reported requires same expected documentation to support code
- The current rules for documenting Other E/M visit (Hospital Observation, Inpatient, ect.) using the 1995 or 1997 guidelines or reported or total time, with documentation that at least 50% being coordination of care or counseling would apply to the code category and level of service reported.
- The 2021 E/M rules for documenting Other Outpatient/Office E/M visits by MDM or Time.
- Suggest using a tracking mechanism to identify the technology used
- Document the justification for the technology assisted service delivery
- Gather and document the medical necessary examination elements as possible under the limited sight and contact with patient along with clinical judgement of the appropriateness as delivered.
- *Suggested notation Justifying technology assisted service delivery:*
  - *Example: Pt presents during COVID-19 pandemic / federally declared state of PHE. Service conducted via (specify telephone or audio/video). Patient is (specify immunocompromised; has co-morbidities posing risk if exposed; exhibiting signs/symptoms /suspicious for COVID-19; diagnosed COVID-19 positive, etc.)"*

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DIGITAL ONLINE EVALUATION "E-VISIT"

MD & Nonphysician practitioners (NPP) CPT® 99421-99423
QNHPs use HCPCS G2061-G2063

Online visit service, for established pt, for up to 7 days of cumulative time during 7 consecutive days…

- 99421/G2061 if cumulative time during seven-day period is 5-10 min
- 99422/G2062 for 11 to 20 min; and
- 99423/G2063 for 21 or more min

Place of Service = provider's usual place of service code

COVERAGE REQUIREMENTS

- Non-face-to-face patient services initiated by est. (or new - during PHE) patient
- Via on-line patient portal inquiry
- Provider must provide a timely response to the inquiry
- Encounter must be stored permanently to report this service
- Reported once in a 7-day period for cumulative time devoted to patient over the 7 days (cumulative time < than 5 min are not be reported)
- New / unrelated problem initiated within 7 days of a previous E/M visit that address a different problem may be reported separately
- Not limited to by setting or location
- Use modifier CS only on visits related to COVID-19 testing

DOCUMENTATION

- Documented Patient Consent (or *by ancillary or provider at least 1x/year*) under GENERAL supervision
- Chief Complaint / Reason for Encounter
- Pertinent History, Exam, Medical Decision Making
- Diagnosis
- Duration of Encounter
- *Suggested notation Justifying technology assisted service delivery:*
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DIGITAL ONLINE AND VIRTUAL CHECK-IN VISIT – RHC / FQHC

RURAL HEALTH CLINIC ("RHC") / FEDERALLY QUALIFIED HEALTH CENTER ("FQHC")

HCPCS G0071

Communication technology-based services for ≤ 5 minutes of a virtual (non face-to-face) communication between a Rural Health Clinic (RHC) or federally qualified health center (FQHC) practitioner and pt. ≥ 5 minutes of remote evaluation of recorded video and / or images by RHC / FQHC practitioner, in lieu of office visit

Place of Service = CMS-1500 = 02 or UB = RevCode 052x

COVERAGE REQUIREMENTS

- Non-face-to-face patient-initiated service for RHC / FQHC pts with billable visits within previous year
- Via phone, video or picture (store and forward), patient portal inquiry
- Providers must provide a timely response to the inquiry
- Encounter must be stored permanently to report this service.
- Reported once in a 7-day period and reported for the cumulative time devoted to the service over the 7 days. (cumulative time less than 5 min are not be reported)
- For condition not related to an RHC / FQHC service provided w/in previous 7 days and does not result in RHC / FQHC service w/in 24 hours or soonest available appointment, as Medicare already pays for the services as part of RHC / FQHC per-visit payment.
- Limited to rural settings or certain locations
- wRVU= 0.39 (nf & f)
- Use modifier CS only on visits related to COVID-19 testing

DOCUMENTATION

- Documented Patient Consent [or *by ancillary or provider at least 1x/year]* under GENERAL supervision
- Chief Complaint / Reason for Encounter
- Pertinent History, Exam, Medical Decision Making
- Diagnosis
- Duration of Encounter
- *Suggested notation Justifying technology assisted service delivery:*
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DISTANT SITE TELEHEALTH SERVICES RHC OR FQHC - HCPCS G2025

At least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian. These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

Place of Service = provider's place of service code

COVERAGE REQUIREMENTS

- Established patient, parent or guardian.
- Expected to be patient initiated, but provider may need to provide beneficiaries information on this specific visit availability
- Requires direct phone / telecommunication between patient or parent/guardian & provider
- Requires a minimum of 5 minutes of time with the patient (or parent / guardian)
- **DO NOT BILL IF** this service results in any visit within 24 hours, next available, or visit by the same provider / specialty within previous 7 days
- No setting / location limitation
- wRVU=1.44 (nf & f)
- Use modifier CS only on visits related to COVID-19 testing
- See: MLN Number SE20016 Revised 12.03.2020 for further detail

DOCUMENTATION

- Documented Patient Consent [or *by ancillary or provider at least 1x/year]* under GENERAL supervision
- Chief Complaint / Reason for Encounter
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- Diagnosis
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