

Telehealth during COVID-19 Public Health Emergency (PHE)
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The most important thing to remember is that payers have differing definitions of what they consider telehealth. I recommend checking with the applicable insurer for the most up-to-date information affecting requirements for coding and billing of telehealth services. A few things to ask about:

- What are the effective dates? Most insurers are limiting this exemption to a specific period of time.
- What services are covered?
- How are those to be billed?
- Do we use telehealth codes or office visit codes?
- What place of service?
- What modifiers are necessary?
- For fee-for-service, traditional Medicare

Medicare

Fee-For-Service Medicare DOES NOT allow telephone calls to be billed as telehealth. The PHE waiver provides three specific exceptions to the existing telehealth regulations:

1. the patient can be in their home or other location - they do not have to be in a healthcare facility in a HPSA.
2. the audio-video link can be something as simple as Skype or FaceTime or Facebook Messenger video calls - but it has to be a real-time audio AND video one-to-one connection, not something public-facing
3. costshare can be waived - it is not automatically, but it can be waived at the providers' discretion.

CMS also stated that they will not audit to verify that there is an established patient relationship. Services are limited to the list of telehealth services at: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

This does include office visits, consultations, Transitional Care Management, and Annual Wellness Visits. Place of service is 02 (zero two) for telehealth. No modifier is necessary unless you are billing from a CAH Method II hospital (GT) or you are treating the patient for an acute stroke (G0). There is also a modifier for a telemedicine demonstration project in Alaska or Hawaii (GQ).

For services that have a site of service differential, payment will be made at the facility rate.

CMS has not specified an end date for these exceptions, just that they will be allowed as long as the Public Health Emergency declaration is in effect.

If there is not a real-time audio-video connection, then you are limited to one of the following:

Virtual Check-In

- 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
- 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

Please note the following restrictions:

- Established patients only (same definition as for other E&M services)
- Verbal consent required and must be documented in the patient's medical record
- No service-specific documentation requirements but medical necessity must be documented.
- May only be billed by those providers who can perform and bill E&M services

For email or portal communication, we also have these codes, new for 2020:

- #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 - ...11-20 minutes
- #99423 - ... 21 or more minutes

Please note the following restrictions:

- Patient-initiated digital communications requiring a clinical decision that would otherwise be made during an office visit
- Physician/Qualified Healthcare Professional (QHP) time only
- Not billable if patient seen in person or through telehealth within 7 day period

For All Payers -

There have been questions on how to perform a visit by phone or audio-video without being able to examine the patient. First of all, established patient visits require two of the three key components: history, examination, and medical decision-making. A visit can be billed based on history and medical decision-making. However, some examination can be done without laying hands on the patient. Observation can be done through video, and sometimes just through audio. A physician can observe skin tone, abnormal movements, respiratory effort and many other exam elements without being able to necessarily touch the patient. A complete Psychiatric exam can be accomplished through talking with the patient.

For example, the patient calls in with complaint of dysuria. The physician documents the complaint (Duration, Timing) and further asks questions about fever, nausea and vomiting (Constitutional and

Gastrointestinal Review of Systems). He also reviews the patient's Past Medical History and Allergies. Based on her previous history, he suspects that the patient has a urinary tract infection and orders an antibiotic.

A patient with asthma calls in with an exacerbation – the physician can actually hear the patient wheezing over the telephone – that would be documented as a problem-focused examination.

The key point is that the physician himself must have the conversation with the patient on the phone or through the audio-video link. This may be something that a nurse may have handled previously, but now it must be performed by the physician to be billable.

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