

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 waiver 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.

Illinois

Compounding the confusion in Illinois is Governor JB Pritzker's Covid-19 Executive Order Number 7 issued on March 19, 2020. Executive Order to Expand Telehealth Services and Protect Health Care Providers in Response to Covid-19 The Executive Order can be read in its entirety at <https://www2.illinois.gov/Pages/Executive-Orders/ExecutiveOrder2020-09.aspx>

The Governor's Executive Order includes the following (not all-inclusive):

- Section 1 “Telehealth Services” shall be defined to include the provision of health care, psychiatry, mental health treatment, substance use disorder treatment, and related services to a patient, regardless of their location, through electronic or telephonic methods, such as telephone (landline or cellular), video technology commonly available on smart phones and other devices such as FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, and videoconferencing, as well as any method within the meaning of “telehealth services” under Section 356z.22 of the Illinois Insurance Code, 215 ILCS 5. “Health insurance coverage” and “health insurance issuer” shall have the meanings given in Section 5 of the Illinois Health Insurance Portability and Accountability Act, 215 ILCS 97.
- Section 2 Beginning March 19, 2020 and continuing for the duration of the Gubernatorial Disaster Proclamation, in order to protect the public's health, to permit expedited treatment of health conditions during the COVID-19 pandemic, and to mitigate its impact upon the residents of the State of Illinois, all health insurance issuers regulated by the Department of Insurance are hereby required to cover the costs of all Telehealth Services rendered by in-network providers to deliver any clinically appropriate, medically necessary covered services and treatments to insureds, enrollees, and members under each policy, contract, or certificate of health insurance coverage. Issuers may establish reasonable requirements and parameters for Telehealth Services, including with respect to documentation and recordkeeping, to the extent consistent with this Executive Order or any company bulletin subsequently issued by the Department of Insurance under this Executive Order. An issuer's requirements and parameters may not be more restrictive or less favorable toward providers, insureds, enrollees, or members than those contained in the emergency rulemaking undertaken by the Department of Healthcare and Family Services at 89 Ill. Adm. Code 140.403(e). Issuers shall notify providers of any instructions necessary to facilitate billing for Telehealth Services.
- Section 3 In order to ensure that health care is quickly and efficiently provided to the public, health insurance issuers shall not impose upon Telehealth Services utilization review requirements that are unnecessary, duplicative, or unwarranted, nor impose any treatment limitations that are more stringent than the requirements applicable to the same health care service when rendered in-person. For Telehealth Services delivered by in-network providers that relate to COVID-19, health insurance issuers shall not impose any prior authorization requirements.
- Section 4 Health insurance issuers shall not impose any cost-sharing (copayments, deductibles, or coinsurance) for Telehealth Services provided by in-network providers. However, in accordance with the standards and definitions in 26 U.S.C. 223, if an enrollee in a “high-deductible health plan” has not met the applicable deductible under the terms of their coverage, the requirements of this Section do not require an issuer to pay for a charge for Telehealth Services unless the associated health care service for that particular charge is deemed “preventive care” by the United States Treasury. The federal Internal Revenue Service recently has recognized that services for testing, treatment, and any potential vaccination for COVID-19 fall within the scope of “preventive care.”
- Section 5 Telehealth Services subject to this Executive Order's coverage requirements may be provided by any in-network physicians, physician assistants, optometrists, advanced practice registered nurses, clinical psychologists, prescribing psychologists, dentists,

occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, other mental health providers, and other substance use disorder treatment providers, as long as they are licensed, registered, certified, or authorized to practice in the State of Illinois, regardless of whether or not the in-network provider was originally established prior to the COVID-19 pandemic in any designated telehealth network for the policy, contract, or certificate of health insurance coverage. Existing insurance law requirements regarding coverage of treatments based on licensure apply, such as the coverage requirements for treatment of autism spectrum disorders contained in Section 356z.14 of the Illinois Insurance Code, 215 ILCS 5.

Section 6 This Executive Order does not apply to “excepted benefits” as defined by 45 C.F.R. 146.145(b) and 45 C.F.R. 148.220, but does apply to limited scope dental benefits, limited scope vision benefits, long-term care benefits, coverage only for accidents, or coverage only for specified disease or illness. This Executive Order applies to short-term, limited-duration health insurance coverage, fully insured student health insurance coverage, and fully insured association health plans except with respect to excepted benefits as provided above. Any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network providers shall be subject to this Executive Order as though all providers were in-network.

Section 7 The Department of Insurance may provide additional guidance and implement rules consistent with the terms of this Executive Order.

Please realize the Governor’s Executive Order does not apply to Original Medicare because Medicare is not regulated by the Illinois Department of Insurance.

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 allow 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.