Telemedicine Q&A

accurate as of 4/2/20

Questions related to telemedicine

- For Medicare and most commercial insurances, telemedicine requires real-time, interactive audio/visual
- If your governor has relaxed the rules in your state, remember that does not apply to Medicare, other federal plans or ERISA plans.
- The codes that may be billed as telemedicine for Medicare are found here. For CPT®, telemedicine codes are listed in Appendix P.

Many questions about what services can be billed via telemedicine (assisted living, hospital visits, TCM, AWV)

There were many questions asking, "Can I bill this or that via telehealth?" There are two lists. CMS expanded its list of covered telehealth services, and we've posted a link to download that on the original telehealth article. There are the original codes allowed via telehealth and some new, temporary additions. Some codes in this article are not considered telehealth, including G2010, G2012, 99421—99423, 99441—99443, and interprofessional consults. We think of them that way because they are not face-to-face codes, but they are not considered telehealth. CPT® has its own list, which does not include HCPCS codes, in Appendix P in the book. These are also indicated by a star next to the code in the book.

What if we just have phone? What if patient refuses to use video or can't make it work?

For CMS, this does not qualify as telemedicine. Use telephone codes 99441—99443.

Do you need a witness for consent?

No.

Can we obtain consent when booking the appointment?

Yes

Do telemedicine office visits need to be patient initiated?

No. This requirement for "patient initiated is for on-line digital E/M codes 99421—99423 which are not considered to be telehealth.

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What if the visual goes out in the middle of the visit?

There is no definitive citation about this.

What if the patient uses Zoom, but can't get the audio to work, can we use the phone to hear them and still see them on Zoom?

This would seem to be real time, interactive audio/visual using two platforms. I don't see why not.

Should we bill Q3014?

No. Q3014 is the code that an originating site used to provide the patient with a room, and the equipment while the practitioner was in a distant site, like another city or hospital. You are not using if for telehealth done from your office to the patient's house.

What if the physician is in the same facility, but in a different room?

This does not qualify currently as telemedicine, per CMS.

What place of service is used for telemedicine?

This is an update. For Medicare, use the place that you would have used if you'd seen the patient in person, and add modifier 95. This will allow you to get paid the non-facility (higher) rate for office visits. If the visit you are doing via telemedicine would have been reported with place of service 11, use POS 11.

Commercial payers will most likely use POS 02.

How much will we be paid? Is it the same as if it were a face-to-face service?

CMS originally was going to use facility rates, which are lower. Now, if you use POS 11, office, you will be paid at the non-facility, higher rate. Other payer policies will vary, depending on what you bill. For a commercial payer, if you bill an office visit with POS 02, I expect the allowable will be the same.

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How do you bill a telemedicine visit if the patient is in assisted living? How would it be billed in a SNF?

There is no difference. Use the assisted living codes or skilled nursing codes, and use interactive, real time, audio and visual communication. Use those codes when the physician/ NP/PA has provided an E/M service via real time audio/visual. Do not use those codes for phone calls or discussion with staff members.

How is it possible to bill AWV by Telehealth to meet all of the required elements? I am questioning the measuring of B/P and determining BMI. would the originating site be responsible for obtaining? Is it acceptable to take patient statement? I am not referring to do an AWV during the lifting of requirements during the emergency state. Just questioning since AWV is listed on the CMS list for telehealth.

I wish I knew! The initial and subsequent wellness visits are on the telehealth list, but not the welcome to Medicare visit. It doesn't make sense. I suppose you could ask the patient their height and weight and calculate the BMI. (If I get to self report those, I'm going to give my accurate and true weight but add a few inches to my height). Some patients may have a blood pressure cuff at home. I just don't know what to say. I wish I had a helpful answer.

Is CMS allowing AWV and Subsequent AWV to be done via telephone during the coronavirus outbreak?

No, you need real-time interactive audio/visual.

My question is regarding advanced care planning. My palliative group is wondering how they can bill these when a patient is not conscious and they have to do ACP Via a phone call with HCR as restrictions have kept patient families and HCR from being present at the hospital. They are only using phone calls for this service. I have not seen any restrictions lifted for this service?

ACP via telehealth requires real-time, interactive audio/visual.

Can preventive medicine services be billed via telemedicine?

No, those codes require a physical exam. Look in your CPT® book, and you'll see there is no star next to those codes indicating telehealth.

What about G0017, for RHCs?

This is not a telehealth service, but is a care management, non-face-to-face service.

We are an outpatient mental health facility. How would we bill if we are still using the office codes 99212--99215?

Follow the directions for office visits. The fact that you are a mental health facility does not change the rules in any way. Look at the list at the top of this article. Many psychotherapy services are on the list.

Can you give an example of documenting a service via telehealth?

This is from a participant:

This visit was conducted with the use of interactive {audio / video} telecommunication that permitted real time communication between @patient name@ and myself. @He / She @ consented to participation and received services at {location}, while I was located at {location}

During this Covid emergency can the telehealth codes and E?M codes be used by specialists like Pain, Ortho GI, to do their follow-up visits via facetime or is this only for primary care type of providers.

These rules are for all specialties. There is no restriction on them by specialty type.

Would there be coverage for physical/occupational therapy provided via telehealth? It is a burning question because the mobility and progress of physical therapy can be lost if patient is not treated - specifically elderly patient.

I originally answered this as a no. However, CMS has added some therapy services as temporary additions to the telehealth list.

What do we do about the exam?

- **How do we document the exam, when doing a telemedicine E/M service?**

  When CMS released the rule on 3/30/2020, they added a section titled, "W Level Selection for Office/Outpatient E/M Visits when Furnished Via Medicare Telehealth." Pp 135-137

  The brief section starts by discussing the upcoming changes in 2021 for codes 99202–99215, in which a practitioner can select a level of service based on total time for the day or MDM. The time spent includes non-face-to-face time that the practitioner spends and does not need to be dominated by counseling.

  CMS is allowing on an interim basis that we apply these rules to office/outpatient visits performed via telehealth during the time of the public health emergency. Specifically, they are removing any requirement for history and/or physical exam. A clinician can use MDM or time to select the code, with time defined as "all of the time associated with the E/M on the day of the encounter." They are using the existing time guidelines. They are keeping the current definitions of MDM, not the revised set that will be implemented in 2021.

  - For 99201–99215 provided via telehealth (real time, interactive audio/visual) a practitioner does not need to use the level of history or exam to select the service.
  - Use total time that the practitioner (not staff) spends on that day, whether or not counseling dominates the visit, **or**
  - Use MDM as currently defined.

  G2010 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

  G2012 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

What is the correct POS for the brief virtual check in?

These are not telemedicine codes. If these were done in the office, use office. Do not use POS 02.

Can an RN/case manager use these G codes?

No, only a physician/NP/PA.

Can you bill G2012 with an E/M?

No

Can you bill G2012 if the patient calls office first to get instructions to log on to telemedicine?

No. I think if you re-read the description of the service and the article on CodingIntel, you will see that these are evaluative, non-face-to-face E/M services.

Would medications call in to pharmacy be included for the G2012?

Do not use G2012 for renewing medications.

What are the requirements to bill G2010 and G2012? does this service requires to have CC, HPI, ROS, PE and A/P including time?

No.

Online digital evaluation and management services

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

G2061 (Qualified non-physician health care professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes);
G2062 11-20 minutes
G2063 21 or more minutes

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Heard yesterday that codes 99421--99423 are not part of the waiver and cannot be used?

- These are not telemedicine codes, so they don't require any waiver. They are covered services for messaging, managing, communicating back to the patient via secure messaging/portal. They do not describe an E/M visit real time, via audio/visual.

- Do not use POS 02, use the place of service where the service is performed, such as office or outpatient clinic.

- These are active codes, with RVUs and payment. Please read the article for more information about how to use them.

  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

Do telemedicine codes 99441-43 qualify to just give results or a refill on RX?

These are telephone codes, not telemedicine. They are used to report patient initiated care unrelated to an E/M service within the past 7 days and not resulting in the next available appointment. If the results related to a prior E/M, I would not use phone call services. I would not use them for routine prescription renewals.

Are telephone service codes covered by Medicare and Commercial plans?

- **99441 - 5 to 10 min**
- **99442 – 11 to 20 min**
- **99443 - 21 to 30 min**

As we are trying to implement TELEHEALTH, many patients do not have access to Facetime or Skype/Zoom and request that we do phone conferences instead. I found the codes above for phone services however they are not in the Medicare Fee Schedule.

These codes are covered by CMS during the public health emergency. They did have a status indicator of non-covered, but CMS changed that.

Interprofessional Internet Consults

99446 Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
99447 11-20 minutes of medical consultative discussion and review
99448 21-30 minutes of medical consultative discussion and review
99449 31 minutes or more of medical consultative discussion and review

99451 Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes of medical consultative discussion and review
99452 Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes

Are Interprofessional Internet Consultations or any similar codes payable during the COVID period or even after?

Yes, these are covered CPT® codes, with RVUs and payment. Please see the article on CodingIntel, and watch the quick video about how to report and document them.

The 99446-99449 codes, can these be billed by a provider who rounds at nursing homes and receives calls frequently from nurses at the facility for orders?

No, these are not for communication with nursing staff at a SNF

Looking for inpatient codes for providers asked to consult but is not actually seeing the patient - how would this be billed; and if patient cannot, unable to have a phone call?

Look at the rules regarding 99446—99449 and see if those meet the situation you are describing.

Are consult codes like 99244 equivalent to the Inter-professional codes? 99446 -99449?

No. 99244 is an in person consultation service. Medicare, and some other payers, do not recognize and pay for consults. Please see the article on 99446—99449.

Scenario 1 - I have a Part B specialist that is in the hospital and there is a patient that has Covid. He has elevated troponins. He does not go in the room and see the patient but is he in the hospital and on the floor/outside the room. He reviews the chart with previous exam, discusses with nurse etc. and does the medical decision making for a consult/new patient visit. What can he bill for this? Hospitals are trying to cautious with the masks/protective wear and use it sparingly so it is there when they really need it. They are already running low.

This appears to be an opportunity to use the interprofessional consult codes.

Scenario 2 – The patient has endocarditis the physician does go in the room but keeps distance from the patient to the extent that he can. He does not do the comprehensive exam. This is a new patient/consult visit. What can he bill?

An initial service based on time. Download the "definitive guide to documenting time" to see the requirements for inpatient services. Or, bill a subsequent visit based on the history, exam and MDM. They only require 2 of 3, not all three.

Other questions

Is there any cross walk from 99441-99423 to regular E/M services for payers that do not cover? And, same question on the G codes?

No, these codes describe completely different services and do not crosswalk.

What is the difference between 99000 and 87635?

99000 is for obtaining a specimen. 87635 is the code for doing the COVID-19 test itself.

If the patient is pregnant and the provider makes a phone call for the monthly visit is that enough to use toward the number of visits for package versus global? Clarifying question for OB care via telehealth, should the modifier be added to indicate that it's telehealth?

Of course, maternity care is not either CMS's or CPT's list of covered telehealth services. There isn't a definitive citation on this, but it seems reasonable. I suggest you ask ACOG, and if you don't mind, let us know what they say.

What place of service should be used for a carside visit in the parking lot?

There isn't a citation for this. I would suggest office, if the parking lot is the office's parking lot.

We are having patients come by the office and a "drive by PCR swab" is being performed after their telemedicine visit. Do you include the billing for the PCR swab with the telemedicine visit?

I would bill the office visit with modifier 95. Place of service depends on the payer. For CMS, use office or outpatient department, or whatever POS you would have used if it had been a face-to-face visit. For commercial payers, use POS 02. For the 99000, place of service office.

A patient is seen through telehealth for UTI symptoms. The provider asks the patient if they could provide a urine specimen for testing. Because the patient is coming into the clinic to provide a specimen, does this change the visit type from a telehealth visit to an office visit?

No, see the example above.

How about if due to COVID, the provider is quarantined to work from home? They can use the telehealth codes, right? Provider at home performing the service via skype and patient at home receiving the service via skype. That is okay, right?

Yes, if the physician is going to work from home permanently, change the address location of the practice. If it is temporary, no action is needed.

See CMS enrollment information here

Would the same thing apply to Medicaid as it does for Medicare?

No, Medicaid is run by the states, and each Medicaid program, can make its own decisions.

Can a NPP bill incident-to if the telehealth service is done in the office under the direct supervision of a physician? The NPP and physician are in the office even though the patient is home. Some believe that Incident To should be approved because CMS states "within their scope of practice and consistent with Medicare benefit rules that apply to all services."

CMS addressed this in the rule released 3/30/2020, and as I read it, it says "maybe." If both the physician and the NPP are in the office and the patient is at home, I believe you can bill it as incident to.

If the physician is supervising the NPP, and they are not in the same physical location, but do have real-time audio/visual access to one another, and the physician could have real-time access to the NPP, I think so. CMS said:

> *"We note that in specifying that direct supervision includes virtual presence through audio/video real-time communications technology during the PHE for the COVID-19 pandemic, this can include instances where the physician enters into a contractual arrangement for auxiliary personnel as defined in § 410.26(a)(1), to leverage additional staff and technology necessary to provide care that would ordinarily be provided incident to a physicians' service (including services that are allowed to be performed via telehealth). " and further, "For the reasons discussed above, on an interim basis for the duration of the PHE for the COVID-19 pandemic, we are altering the definition of direct supervision at § 410.32(b)(3)(ii), to state that necessary presence of the physician for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider."*

I think based on this that you can still bill incident to if the physician is available to have real time audio/video with the NPP and the patient. Note, you need the availability for real time audio/visual with both the NPP and the patient, as I read it.

What about shared services?

There isn't any guidance about shared services. If both the NPP and the physician are in the same location, and both have a real time, interactive, audio/visual visit with the patient, I think so.

Has there been a change in the teaching physician rules?

Yes. I will be adding an article about the topic Friday, April 3.