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PIVOT POINT PERSPECTIVE

Today's Telehealth Billing & Coding Requirements.

Telehealth billing and coding regulation changes.

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act and Section 1135 waiver authority, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services during this public health emergency so beneficiaries can get a wider range of services from their doctors and other clinicians without traveling to a healthcare facility. Under this Section 1135 waiver expansion, physicians, nurse practitioners, psychologists and licensed clinical social workers and others can offer a specific set of telehealth services including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. Additionally beneficiaries can get telehealth services in healthcare facilities – including a physician's office, hospital, nursing home or rural health clinic – as well as their homes.

How To Bill Telehealth Visits.

Medicare telehealth services are generally billed as if the service is furnished in person. The claim should reflect the designated Place of Service (POS) code 02-Telehealth to indicate the billed service was furnished as a professional telehealth service from a distant site.

Providers will need to apply for any waiver that wasn't included in the blanket waivers approved as part of the COVID-19 pandemic if they wish to seek relief in additional areas. The request for waiver should be emailed to the CMS Regional Office in their service area. Providers should also check their specific state requirements for full details based on where they are located to understand how they should be handling telehealth for Medicaid patients.

Additionally many states have waived licensure requirements to allow providers to virtually treat patients across state lines. Providers should check the Federation of State Medical Boards (FSMB) for the most up to date list as things continue to evolve.

Health Insurance Portability and Accountability Act (HIPAA)

The HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information visit **www.hhs.gov.**

Telehealth Documentation Requirements

- ✓ Patient consent
- ✓ Patient location
- ✓ Chief complaint or reason for the visit
- ✓ Justification for telehealth service – "patient presents during the COVID-19 pandemic and this service is being provided via (specify what method) and due to (document clinical picture that would puts the patient at risk for an in-person visit or could potentially be contagious with the virus) as the reason for being treated virtually"
- ✓ Pertinent history, exam and medical decision making
- ✓ Diagnosis
- ✓ Duration of the encounter

Types of Virtual Services That Can Be Offered.

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries.

MEDICARE TELEHEALTH VISITS: *Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.*

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- The requirement that the patient has a prior established relationship with a particular practitioner will not be subject to audit for any claims submitted during this public health emergency.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

VIRTUAL CHECK-INS: *In all areas (not just rural), established Medicare patients may have a brief communication service in their home with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image.*

- Regulations state virtual services should be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation.
- Medicare pays for "virtual check-ins" (or brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office.
- Virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).
- Visits should be coded with HCPCS code, 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).

- If the patient submits some type of video or image HCPCS code 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) should be used.

E-VISITS: *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.*

- 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.
- Services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.
- Patient must verbally consent to receive virtual check-in services.
- Medicare Part B also pays for e-Visits or patient-initiated online evaluation and management conducted via a patient portal.
- Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill 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

Questions to ask your organization.

- What will our standard language be for *justification of telehealth service* for documentation purposes?
- Will our organization permit the use of non-HIPAA compliant technologies such as Facetime or Skype?
- Are my consent forms inclusive of services provided via telehealth?
- How do we rapidly educate and ready our providers, as well as billing and coding staff about the changes?

The information provided here is current as of 3/30/20. Please contact our Telehealth specialists at **800-381-9681** *or* **letschat@pivotpointconsulting.com** *for updates or questions.*