COVID-19 RESPONSE WEBINAR SERIES: LESSONS LEARNED ON BILLING IN THE AGE OF COVID

WEBINAR Q&A FOLLOW-UP

ANSWERS IN THIS Q&A ARE UP TO DATE AS OF MAY 22,2020

ARE YOU AWARE OF A CPT CODE WE CAN USE TO BILL FOR A COVID-19 TEST COLLECTION ON THE SAME DAY AS AN E/M?

When a COVID-19 swab is performed on the same day as an E/M it is included in the E/M. This is for both Medicare and commercial payors.

PLEASE CONFIRM THE CODES THAT APC'S SHOULD USE FOR TELEHEALTH SERVICES. 99441 SERIES OR OTHER?

We suggest you contact your local MAC (Medicare carrier) for hospital-based billing. There is a lot of confusion surrounding how to bill for telehealth services on a UB-92, and CMS is still working on an answer.

WOULDN'T POST OP VISITS BE BILLED AS 99024 AND NOT WITH A TELEHEALTH VISIT CODE?

Yes, post op visits would still be billed with code 99024, even if performed via telehealth. This code should be submitted to the carrier for reporting purposes only.

FOR THESE %'S ON THIS SLIDE ABOUT DENIALS, WHAT TYPE OF SERVICES/SPECIALTIES IS THIS FOR?

The main specialities that responded are Orthopedics, Otolaryngology, Neurosurgery, and General Surgery.

SOME ARE TELLING US TO USE THE G CODES VS THE HOSPITAL CODES. ANY OPINION ON THAT?

Each payor may have different guidelines for using G codes. As long as you are documenting and choosing the codes according to the service performed (not just choosing a G code because it pays), then follow the individual payor guidelines when using G codes.

IF THE VISIT STARTED AS A VIDEO/AUDIO AND THERE WERE PROBLEMS WITH CONNECTION AND TRANSFERRED TO A TELEPHONE CALL. HOW WOULD THAT BE BILLED? TELEPHONE CALL OR TELEHEALTH W/VIDEO AND AUDIO?

There is no written guidance on this that I have found. Since you can only bill for one service on the same day, I would suggest calculating the time for each service and bill for whichever service was greater (meaning how the provider spent most of his/her time during the visit). Either by audio w video or by phone. You should not add the two service times together as they are different services.

FOR IN HOSPITAL PATIENTS (ER, OBS, INPT) DOES SPEAKING BY TELEPHONE WITH THE ADMITTING ATTENDING SERVICE AND COORDINATING CARE PLUS REVIEWING LABS, EHR AND IMAGES AND GENERATING A REPORT ON THE EHR BUT NO VIDEO OR CONVERSATION WITH THE PATIENT CAN ONE BILL FOR AN INITIAL OR SUBSEQUENT HOSPITAL VISIT LIKE 99221-99223 AND 99211-99233, OBS CODE

No. All telehealth and phone calls are based on provider to patient interaction. If you would not bill for these types of services under "normal" or usual conditions, then you should not bill for these during the current health crisis. However, keep in mind that interprofessional consultations (99446-99447) are available for use if all criteria are met.

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IF A PATIENT HAD AN E&M TELEHEALTH VISIT AND THEN A SECOND TELEHEALTH VISIT 1 WEEK LATER, CAN YOU BILL FOR BOTH? EXAMPLE APPOINTMENT 4/21 AND 4/28.

If both visits were audio with video (real-time) visits, AND they were both medically necessary and documented as such - then yes. You can bill for both visits just as you would for office visits if the patient required 2 office visits a week apart. Telephone visits have different requirements, so they would not be billed as separate calls.

CAN YOU PROVIDE THE TELEPHONE CALLS CODES WITH CROSS OVER CODES TO 99211-99214?

Each telephone code crosses over to the wRVU and allowable as follows: 99441=99212; 99442=99213; 99443=99214

HAS ANYONE BEEN ABLE TO FIND ANY PAYER INFORMATION SPECIFIC TO COVERAGE UNDER TELEHEALTH FOR PREVENTIVE/WELLNESS VISITS? WE KNOW THAT CMS WILL COVER HOWEVER MUST BE PERFORMED UNDER THE TELEVISUAL PLATFORM (AUDIO/VIDEO) AND CANNOT BE PROVIDED VIA TELEPHONE ONLY.

CMS has an up to date list to answer this question. Column D on their spreadsheet will tell you if a code can be billed via video only. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .

JUST TO CLARIFY, TELEPHONE ONLY VISITS ARE CODED BY TIME ONLY USING 99441-99443.

Yes, for telephone calls only the provider's time on the call is calculated, not the total time (pre/intra/post) the provider spends in preparing for the call or after the call.

DO YOU HAVE ANY GUIDANCE FOR PROVIDERS BRINGING PATIENTS IN FOR PRE-OP EXAMS? THEY ARE ONLY ASSESSING THE PATIENT FOR COVID-19 SYMPTOMS AND SWABBING FOR COVID-19.

CMS addresssed this in one of their Provider calls to say that if an additional pre op visit was required to swab for COVID-19, then that visit could be separately billable as it would be considered a potential change in patient status. The visit can be billed separately if testing is required.

I HAD A PROVIDER BILL BOTH AN E/M CODE & A TELEMED CODE ON THE SAME DOS. I WOULDN'T THINK THIS IS APPROPRIATE, BUT I WANTED TO VERIFY.

You are correct, they can only bill for either a telehealth visit (99201-99215) or a telephone call on the same day, not both.

HOW DOES BILLING WORK FOR IN HOSPITAL PATIENTS LIKE ER, OBS, INPT? DOES THERE NEED TO BE A CONVERSATION WITH THE PATIENT? IS VIDEO WITH PATIENT NECESSARY?

CMS has an up to date list to answer this question. Column D on their spreadsheet will tell you if a code can be billed via video only. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .

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LAST WEEK THE AMA PRESENTATION ADVISED THAT IN THE CLINIC WECOUULD BILL THE 99211 IF THE PATIENT HAD A TELEMEDICINE ENCOUNTER EARLIER THAT SAME DAY AND WAS TOLD TO COME BACK INTO THE CLINIC FOR A SWAB

Yes. This is our understanding as well. If the patient has 2 separate encounters.

ARE YOU ABLE TO BILL FOR A TELEPHONE OR VIDEO VISIT FOR AN ANNUAL PHYSICAL (99391-99397)?

CMS has an up to date list to answer this question. Column D on their spreadsheet will tell you if a code can be billed via video only. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

FOR TELEPHONE VISITS, WHAT CODES ARE WE SUPPOSED TO USE? 9924X CODES?

99441-99443 for providers who bill office visits, and use 98966-98968 for providers who do not bill office visits (PT, OT, SLP, dietician, etc.).

IS A TELE-VISIT BILLABLE IF NO TIME WAS DOCUMENTED? WOULD IT BILLABLE AT ALL?

If you mean telephone only visit then no it is not billable, as the visit is based on time alone. If billing for telehealth visits(99201-99215) documentation of time is not required. It can be used for billing the level but documentation is not required.

IF A PA CALLS A PATIENT TO ANSWER SOME QUESTIONS REGARDING A RECENT TELEMEDICINE VISIT CAN WE BILL FOR THE PHONE CALL (AUDIO ONLY) UNDER THE PHYSICIAN?

If the call is related to a prior E/M within the last 7 days, or leads to an E/M within the next 24 hours (or soonest available) then you cannot charge for the call.

SOME CARRIERS ARE WAIVING CO PAYS IF THE TELEMED IS RELATED TO COVID-19. IF THE PHYSICIAN SPOKE TO PATIENT BECAUSE THEY THOUGHT THEY HAD THE VIRUS. THE PHYSICIAN RULED OUT THE VIRUS AND NO TESTING ARE NEEDED. IS THERE ICD10 WE SHOULD USE TO RULE OUT COVID-19?

Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out is the code for this. If the patient has symptoms, then you would also list the appropriate diagnosis code(s) in addition to Z03.818.

ANY IDEA ABOUT PRIMARY CARE / URGENT CARE?

Telehealth visits are very helpful for primary care and somewhat for urgent care. We recommend you look at the list on the CMS website for a complete listing of telehealth services available, as your specialty has quite a few options, including AWVs.

WHICH FREE TELEHEALTH PLATFORM SEEMS TO WORK BEST FOR EVERYONE? DO YOU HAVE THAT INFO? DOXY.ME VS VSEE??

We can't answer that question as each practice has different needs. However, there are websites that rate telehealth platforms and they give ratings. You can find them easily with your browser of choice.

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IN LIGHT OF THE PANDEMIC, HAVE YOU HEARD ANY CREDIBLE DISCUSSIONS ABOUT POSTPONING THE E/M CODING CHANGES SCHEDULED TO BE IMPLEMENTED IN 2021?

No. At KZA all the consultants believe that the 2021 guidelines are moving forward as planned. Change is not easy, but the new guidelines are designed to decrease provider documentation burden. Visit KarenZupko.com for upcoming classes that include detailed education regarding the new 2021 guidelines.

WHAT ABOUT IF THE CALLS GET DROPPED, IT'S REALLY HARD TO KEEP TRACK OF IT ON PLATFORMS SINCE LITTLE INFORMATION IS KEPT CONNECTING WITH A CERTAIN PATIENT ENCOUNTER.

Understood and this is a common issue, especially since everyone is using bandwidth and cell phones now more than ever. You may want to jot down a paper note to track your time, but remember that all documentation should be kept in the permanent medical record. You may want to document that technical difficulties prolonged the service time in order to explain to the payor any extenuating circumstances.

DOES THE AUTH NEED TO BE IN A SEPARATE NOTE OR CAN IT GO IN THE MEDICAL NOTES?

Patient consent for the telehealth visit or call should be documented within the progress note. It can be a verbal consent, with written consent obtained later to keep in the chart.

ON YOUR WEBSITE THERE IS A CHART THAT CAME FROM THE AAFP THAT SAYS THAT THERE IS AMA TIME AND CPT TIME IS DIFFERENT? WHERE DID YOU FIND THIS ON CMS SITE?

That information was in the first interim final rule. However - the information has changed and CMS is now using the same times as CPT, since it was too confusing for providers and clinics to follow. Our information has been updated to reflect the new changes.

ONE OF MY PROVIDERS WOULD LIKE TO CONTINUE WITH TELEMEDICINE AFTER THE PHE. IS THERE A POLICY FOR WORKERS' COMPENSATION COMPANIES?

We have not heard from any of the Workers' Compensation carriers on this. We encourage you to reach out to your top WC payors for guidance.

OUR CLINIC HAS A TELEMED BLURB AT THE END OF OUR TELEMED NOTES, EVEN FOR PHONE CALLS. SHOULD THIS BE REMOVED FOR PHONE CALLS?

If the "blurb" is a blanket statement about telehealth visits (audio with video) then it would not apply, so may be less confusing to remove it. However, if it explains that the visit was conducted as a telephone call, then it should be included. All telehealth visits should have documentation within the progress note explaining that the visit was either conducted via a real-tie audiio with video call, or a telephone call for coding clarity sake and in case of a later audit.

ARE PAYORS ANNOUNCING END DATE FOR TELEHEALTH VISITS. I BELIEVE AETNA OR CIGNA SAID POLICY WAS EFFECTIVE UNTIL JUNE 6, 2020.

While some payors did set end dates, as we have all learned throughout this pandemic - dates may change. We suggest reaching out to your top 5-6 payors in your area for more clarification.

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IS THERE A CONCERN ON THE CURRENT TELEMEDICINE GUIDELINES ONCE COVID-19 IS OVER. WITH EXPLAINING TO THE PHYSICIANS, THE "ACTUAL" GUIDELINES FOR TELEMEDICINE AND HOW TO STOP THE TELEMEDICINE VISITS FOLLOWING THE PANDEMIC GUIDELINES

Just as the current situation is fluid - we encourage adminstrators, managers, coders, and billers to maintain an open line of communication with your providers. We don't know how long this will last, so staying informed is the best course of action.

DOES THE AUTH FROM THE PATIENT TO ACCEPT TELEHEALTH HAVE TO BE A SEPARATE DOCUMENT OR CAN THE PROVIDER ADD THE COMMENT IN THE NOTE?

The patient should sign a separate consent form. However, HHS does not want a formal form to get in the way of a pateint receiving care. A verbal consent is required and should be documented within the progress note. As of Jan 1, 2020 a single consent form for telehealth can be obtained for multiple telehealth services on an annual basis.

CAN TELEHEALTH SERVICES BE INCIDENT TO? IF A CARRIER DOES NOT RECOGNIZE APPS, CAN WE STILL BILL UNDER MD INSTEAD?

This is discussed in our FAQs and other materials on the Telehealth page at KarenZupko.com

BESIDES THE NEWLY ADDED PTS, OTS, SLPS, ARE THERE OTHER CLINICIANS WHO CAN BILL UNDER MEDICARE DURING THE PHE?

Visit our website and view our resources on the Telehealth page at KarenZupko.com.

I AM A CODER FOR PODIATRY SERVICES. MY DOCTOR HAD A TELEMEDICINE VISIT WITH A NURSING HOME PATIENT. WOULD THIS BE PAYABLE CONSIDERING THE COMMENT MADE CONCERNING THE PT RECEIVING HOME HEALTH SERVICES AT THE SAME TIME OF A TELEMEDICINE VISIT?

Home health care is given in the patient's home and nursing home visits have their own place of service code, so this should not be an issue. This is also only an issue for provider based (some say hospital based) clinics.

WHEN YOU SPOKE ABOUT THE EXAM PORTION OF THE TELEHEALTH. I AM HAVING A HARD TIME HOW THE PROVIDER WILL DOCUMENT THIS. CAN PROVIDE AN EXAMPLE OF A DOCUMENT NOTE?

This is the very reason that CMS said you can now use medical decision making OR time for calculating a level. Any element of an examination that can be assessed through direct observation or inspection can be documented as performed. If you look at the 1997 General Multi-system Exam bullets, you can see the options.

CAN PAPER CLAIMS BE SUBMITTED FOR TELEHEALTH SERVICES OR SHOULD THEY BE DONE VIA EHR ONLY?

Claim submission rules have not changed. If you were sending paper before the pandemic, then paper claims can be sent. If you were sending claims electronically then electronic claims should be sent.

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IF YOU BILLED MEDICARE TELEHEALTH AND DIDN'T APPEND MOD 95 AS IT WAS PRIOR TO THEIR CHANGE AND RECEIVED REIMBURSEMENT ALREADY WOULD YOU RECOMMEND SENDING A CORRECTED CLAIM WITH THE MODIFIER?

Medicare just announced that they will go back and reprocess any claims for telephone only E/M services that were paid at the lower level from March 1st forward. They will also automatically reprocess the following codes that denied improperly (CPT codes 90785, 90833, 90836, 90838, 96160, 96161, 99354, 99355, and G0506). You do not need to resubmit claims for these services. For all other denials you would need to resubmit claims.

CAN YOU BILL MEDICARE IF THE PHYSICIAN SPOKE TO THE PATIENT'S DAUGHTER? THE PATIENT WAS WITH THE DAUGHTER AT THE TIME OF THE CALL.

Unless the patient is incapacitated due to medical issues (unconscious, dementia) and the daughter is a legal guardian the call must be provider to patient to justify a billable telephone visit. If the daughter is an "independent historian" this is accepatable for obtaining history, but otherwise the patient should be the one interacting directly with the physician on the call.

THE SUPERVISION REQUIREMENTS DURING THIS PHE HAVE BEEN RELAXED BUT IT'S NOT CLEAR BETWEEN THE WRITTEN INFORMATION AND THE VERBAL EXPLANATIONS BY CMS AND LOCAL MACS.

1. DOES DIRECT SUPERVISION REQUIRE REAL-TIME, INTERACTIVE VIRTUAL SUPERVISION AT THE TIME OF THE SERVICE? OR DOES THE SUPERVISING PHYSICIAN ONLY NEED TO BE "IMMEDIATELY AVAILABLE?"
2. FOR TEACHING PHYSICIAN SUPERVISION, AGAIN IS THE SUPERVISION REQUIRING REAL-TIME AUDIOVISUAL SUPERVISION AT THE TIME THE RESIDENT IS PROVIDING THE SERVICE? OR DOES THE TEACHING PHYSICIAN ONLY NEED TO BE IMMEDIATELY AVAILABLE VIA VIRTUAL MEANS?

The new definition of direct supervision does include virtual supervision. This requires the physician to be on a real time, audio with video session. They cannot simply be immediately available, they must be online in a video session. The same is true for teaching physicians, as virtual supervision would qualify. However, all other teaching physician requirements remain the same (ie cannot have other duties while supervising, etc.).

CAN A YEARLY CONSENT BE SIGNED AND REFERRED TO IN DOCUMENTATION AT SUBSEQUENT TELEMEDICINE VISITS?

Yes. Consent must be obtained annually and must be documented within each progress note.

DO YOU KNOW IF ANY INSURANCE IS COVERING THE ANTIBODY TEST 86328?

We have a KZA Alert on the Telehealth web page that discusses lab testing. However, for individual payor information we advise you to reach out to the specific payors.

BASED ON PAYOR POLICY FOR SOME COMMERCIAL PLANS WE HAVE FOUND THEY WILL NOT ACCEPT THE 99441-99443 SERIES CODES FOR TELEPHONE ENCOUNTERS, WE ARE NOW TASKED TO RE CODE THESE ACCTS TO E/M LEVELS. YOU MENTIONED EARLIER THAT THESE TELEPHONE CODES DIRECTLY CORRELATE TO THE 99212-99214 CODES. IS THIS TO SAY WE

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CAN JUST AUTO ADJUST THEM, OR DO THEY REQUIRE NEW REVIEW TO POSSIBLY INCORPORATE MDM INTO THE MIX NOW?

We would not recommend auto adjusting, as each payor may not crosswalk the telephone codes directly to 99212-99214, as CMS does. We suggest contacting the specific commercial plans for guidance.

BACK TO COVID-19 SWABBING PATIENTS, WE WOULDN'T USE 99000?

99000 is not payable for most payors, and the AMA as well as CMS tells us to use 99211 for both new and established patients when no other E/M service is provided when a swab is obtained in the office.

I CANNOT FIND YOUR TELE HEALTH PAGE BY GOING TO KARENZUPKO .COM

You can either scroll down on the main page KarenZupko.com or go to the dedicated Telehealth page at karenzupko.com/KZA-telehealth-solution-center-access

CAN YOU BILL FOR THE COVID-19 TEST WITHOUT A CLIA#?

You need a CLIA certificate of waiver in order to perform the CLIA waived tests in your office. You do not need a CLIA certificate of waiver in order to collect a specimen and send to an outside laboratory to complete the test.

CAN A PREGNANCY CONFIRMATION BE DONE VIA TELEPHONE/VIDEO CALL? IF SO, WHAT DX IS APPROPRIATE?

That is a clinical decision that a provider should answer. The diagnosis used should be the diagnosis you would normally use for face to face services. If pregnancy cannot be confirmed, then you should code the diagnosis according to symptoms.

I APOLOGIZE IF THIS WAS ALREADY STATED BUT WILL THERE BE AN AAPC CEU FOR THIS WEBINAR?

There are no CEUs associated with this particular webinar.

DO YOU HAVE A FORM WE CAN USE DURING A TELEHEALTH VISIT WITH THE NEEDED INFORMATION?

We do not have forms, but encourage you to work with your EMR software company do develop a telehealth template for these visits.

DO TELEHEALTH VISITS FOR A SPECIALIST ALSO REQUIRE A REFERRAL THE SAME AS FOR AN ACTUAL VISIT?

Referral rules have not changed during the COVID-19 pandemic. If the insurance requires a referral, then a referral must be obtained. Consultation rules have not changed either, so all consultation referral requirements remain the same.

I KNOW THAT AUDIO/VIDEO E/M SERVICES CAN BE BASED ON THE PROVIDERS TOTAL TIME. HOWEVER, FOR AUDIO ONLY TELEPHONE CALLS, CODES 99441 - 99443 SPECIFY "MINUTES OF MEDICAL DISCUSSION". SOUNDS LIKE THIS IS NOT TOTAL TIME. IS THIS CORRECT?

Correct, telephone calls to not allow for billing pre and post call workups. For telephone calls you can only count the minutes for the provider's time on the call.

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WHERE DO WE GO TO FIND THE PAYOR TELEHEALTH POLICIES?

www.karenzupko.com/KZA-telehealth-solution-center-access

DID I HEAR CORRECTLY TO USE MODIFIER 95 ON TELEPHONE AUDIO ONLY?

Yes. As telephone calls are now covered telehealth services (temporarily) you would need to add modifier 95.

I READ THAT CMS DOES NOT WANT A MODIFIER ADDED TO 99441-99443 AND WANTED THEM BILLED SIMPLY AS TELEPHONE VISITS. IS THIS CORRECT?

Telephone calls are now listed as telehealth services, so modifier 95 should be used for telephone calls.

PAYOR TELEHEALTH POLICIES CHART STATES "MODIFIER FOR TELEMEDICINE (NOT EVISITS, PHONE CALLS, OR VIRTUAL CHECK-INS) - IF I AM UNDERSTANDING CORRECTLY IT WAS SAID THAT EVEN ON PHONE CALLS MEDICARE WARRANTS MODIFIER 95? CAN SOMEONE CLARIFY THIS PLEASE?

CMS wants modifier 95 on telephone calls, however, other payors may have their own guidelines. So follow the guidelines listed on the Payor Telehealth Policies.

PLEASE ADVISE ON CS MODIFIER AND THE ORDER IN WHICH WE REPORT WITH 95 MODIFIERS

I would list 95 then CS, but there is not written information specifying a hierarchy.

MODIFIER-95 FOR MEDICARE WOULD I NOW USE THIS ON CODES 99441-99443? THE ONE SLIDE YOU REFERENCED SAID NOT FOR PHONE CALLS.

Yes telephone calls should have modifier 95 for Medicare. The document on the KZA web page has been updated.

IS THE GT MODIFIER STILL BEING ACCEPTED BY SOME PAYERS OR HAS MODIFIER 95 TAKEN ITS PLACE?

Some payors prefer modifier GT over modifier 95, it is definitely payor specific.

WHAT IS THE GT MODIFIER FOR?

Visit our website and view the resources on the Telehealth page at www.KarenZupko.com.

IF YOU DO A POSTOP 99024 VISIT VIA TELEHEALTH, DO YOU STILL BILL WITH MODIFIER -95?

This has not been addressed by CMS and is not payable. It is for recording purposes only it may or may not affect the claims being processed.

WHEN CODING MEDICARE TELEMEDICINE, IF THE PATIENT IS AT HOME, IS THE PROPER CODE A 02 OR 11?

The place of service would be 11 if you would normally see the patient face to face in your office. If you perform telemedicine visits usually and don't see patients in an office, then you would use place of service 02.

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WHERE DO WE BILL, WHERE THE PATIENT IS OR THE PROVIDER IS?

The place of service would be 11 if you would normally see the patient face to face in your office. If you perform telemedicine visits usually and don't see patients in an office, then you would use place of service 02.

IF THE PATIENT IS IN INPATIENT STATUS, AND THE PROVIDER SAW THE PATIENT VIA AUDIO/VISUAL, IN THE SAME LOCATION BUT DIFFERENT AREA OF THE HOSPITAL, IS THAT CONSIDERED TELEHEALTH.

No, according to CMS this is not a telehealth service as both the provider and patient are in the same location.

ORIGINALLY, CMS STATED IF PROVIDER WAS AT HOME PROVIDING TELEHEALTH SERVICES, THE PROVIDER HOME ADDRESS SHOULD BE ON THE CLAIM, IS THAT NOW WAIVED?

No changes have been made to this guideline. If the provider is seeing patients 100% of the time at home for whatever reason then he/she would put their home address on the claim. When the provider returns to a clinic, then the provider address would revert back to the clinic address.

OUR CHALLENGE IS BILLING TELEMEDICINE FOR OUR PBB CLINICS. ANY SUGGESTIONS?

Provider based clinics can bill for telehealth services as long as the hospital registers the patient as an outpatient for the visit and home health services are not provided to the patient at home during the time of the telehealth service.

FOR SPEECH THERAPY CPT 92507 MEDICARE PATIENTS. WE ARE PROVIDER BASED, SO NORMALLY WE WOULD ONLY BILL MEDICARE PART A FOR THIS SERVICE. WOULD WE HAVE TO CHANGE HOW WE BILL THIS SINCE THE SPEECH THERAPY IS BEING DONE VIRTUALLY?

CMS is still deciding how to handle billing for professional services on the UB-92. Unfortunately we don't have any guidance for this at this time.

DO YOU HAVE INFORMATION ON BILLING THE TECHNICAL PORTION OF A PROVIDER BASED CLINIC?

Hospitals can now bill for Q3014 when the patient is at home and registered as an outpatient of the hospital for the duration of the provider visit.

FOR HOPD CLINIC BILLING, DOES THE PROVIDER NEED TO BE IN THE CLINIC FOR REIMBURSEMENT?

The billing provider can be located in any location except the same location as the patient. This is true for providers in an independent office (POS 11) or a provider based clinic (POS 19).

CMS IS ALLOWING HOSPITALS TO BILL THE ORIGINATING SITE FACILITY FEE, Q3014. CAN YOU EXPLAIN HOW THIS WORKS? IS IT IN LIEU OF BILLING FOR THE SERVICE?

As long as the pateint is registered as an outpatient during the visit (as they will physically be at home), then hospitals can bill for Q3014. For more information on this see the Interim Final Comment (IFC) from April 30th at https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

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JUST TO MAKE SURE I UNDERSTOOD THE HOME HEALTH INFO. IF WE HAVE A PATIENT THAT HAS A CERTIFICATION PERIOD OF HOME HEALTH WITH ONE OF OUR PROVIDERS FROM 03/01-05/01 WE CANNOT BILL A TELEHEALTH VISIT DURING THAT TIME FRAME:

No. The provider based clinic physician cannot bill for a telehealth visit on the same date at the same time that home health care is at the patient's home performing a visit. Home health care can only be performed when the patient is in the place of service "12 Home", and the provider based clinic can only bill for a visit when the patient is registered (at home) as an outpatient of the hospital, so both cannot occurr at the exact same time of a single day.

CMS INCREASED THEIR REIMBURSEMENT FOR TELEMEDICINE AUDIO AND AUDIO/VIDEO RETROACTIVE TO MARCH 1, 2020. THESE FEES ARE NOT POSTED YET. WHERE CAN I FIND THESE NEW TELEMEDICINE RATES?

CMS increased the allowables for telephone only codes 99441-99443 to correspond with 99212-99214. This is noted in the Interim Final Rule from April 30th.

EQUAL REIMBURSEMENT WHEN COPAY IS COLLECTED FOR VISIT CODES WHEN TELEHEALTH VS IN OFFICE VISITS FOR MOST COMMERCIAL?

Commercial payors each have their own reimbursement guidelines. A lot of commercial payors are waiving copayments. Check the Payor Telehealth Policies article on the KZA Telehehealth web page.

ARE YOU AWARE IF MEDICARE WILL RETRO THE INCREASED PAYMENTS FOR TELEPHONE CALLS BACK TO MARCH 1ST?

Yes. They have said that they will reprocess all telephone only visits back to March 1st and pay the corrected higher rate. We suggest you keep a close eye on this and follow up with them in a few weeks if you don't see these claims being reconsidered automatically.

DO YOU KNOW WHY MEDICARE HAS NOT UPDATED THEIR FEE SCHEDULE YET TO CORRESPOND THE CORRECT PAYMENTS FOR THE 99441-99442 CODES. I LOOKED AT A REMIT THIS MORNING FOR MEDICARE CHECK THIS WEEK AND THEY ARE STILL PAYING OLD FEE AMOUNTS. I ALSO CHECKED PALMETTO WEBSITE AND THE FEES WERE LAST UPDATED IN MARCH.

Medicare said that they are in the process and will automatically reprocess claims for telephone services back to March 1st. We recommend you check with your local MAC for further direction.

DO YOU NEED TO CHANGE YOUR FEE SCHEDULE FOR TELEPHONE CALLS IN ORDER TO GET PAID AT THE E & M LEVEL?

If your fee is above the allowable , then this should not affect your reimbursement. If you bill Medicare at the Medicare allowable rate, you would increase your fee according to CMS' new directed codes 99212-99214 for telephone only codes 99441-99443. Of course this is temporary, and CMS may not pay for telephone calls after the crisis is over.

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FOR TELEPHONE VISITS, WHAT CODES ARE WE SUPPOSED TO USE? 9924X CODES ARE NOT CMS APPROVED CODES

CMS added telephone calls as temporarily covered services in March, and then added them as telehealth services and increased the allowables (not on the Provider lookup listing yet) on April 30th. So you would use 99441-99443 for telephone calls. Other payors may require you to bill office visit codes(99201-99215) instead. Check with your payors..

ARE COMMERCIAL PAYERS GOING TO INCREASE REIMBURMENT FOR TELEPHONE CALLS LIKE MC IS?

This is payor specific. We encourage you to check with your top 5 payors in your region.

WE ARE HAVING PROBLEMS GETTING REIMBURSED FOR TELEPHONE VISITS FOR PSYCH PATIENTS.

These visit should be appealed, as they are covered services. It would be worth the time to have your business office call your top payors for clarification, as these services should be covered.

CAN YOU EXPLAIN THE DIFFERENCE BETWEEN BILLING MEDICARE FOR PHONE ONLY VERSUS AUDIO AND VISUAL? WHICH CODES SHOULD BE USED FOR EACH? IS MEDICARE PAYING THE SAME AMOUNT FOR EITHER PLATFORM?

Real time with audio AND video visits can be billed with office visit codes (99201-99215) and audio only calls should be billed with telephone codes (99441-99443). They are allowing 99441-99443 at the same rate as 99212-99214 respectively.

IS TRICARE THE ONLY PLAN NOT PAYING FOR PHONE VISITS AUDIO ONLY CALL?

Each payor has different guidelines. We suggest you contact your major payors in your practice to have the information as a baseline.

HOW DO WE BILL FOR THE HOSPITAL MEDICAL RECORDS REVIEW THAT LEAD TO AN AUDIO ONLY ENCOUNTER WITH THE PATIENT? WOULD THE TIME SPENT ON THE RECORDS REVIEW CONTRIBUTE TO THE TOTAL TIME BILLABLE FOR 99441-99443? IF THE DOCTOR SPENDING MORE THAN 30 MIN ON HOSPITAL RECORDS REVIEW, ARE WE ABLE TO USE 99358 IN CONJUNCTION WITH THE TELEPHONE ONLY ENCOUNTER?

Unfortunately the only telehealth covered prolonged services are for face to face encounters. While telephone calls are now considered telehealth services, they are not face to face encounters (like real -time audio with video calls), so cannot bill prolonged services with telephone only calls. And for telephone only calls, you can only count the provider's time spent on the call with the patient. You cannot count time before or after the call. This is different that the telehealth E/M visits (99201-99215) where you can count time spent reviewing records.

IS THERE A DIFFERENCE WITH PROVIDER TIME VS TOTAL TIME BECAUSE WE HAVE MAS ASK THE HPI TO START, SHOULD WE INCLUDE THIS INTO THE TOTAL TIME?

Total time (pre/intra/post) is only for telehealth E/M services, not for telephone calls. And the only time you count is the time of the billing provider, not staff time.

COVID-19 RESPONSE WEBINAR SERIES: LESSONS LEARNED ON BILLING IN THE AGE OF COVID

WEBINAR Q&A FOLLOW-UP

ANSWERS IN THIS Q&A ARE UP TO DATE AS OF MAY 22,2020

WITH CMS ALLOWANCE TO BILL E/M BASED ON TIME INCLUDING NON-FACE-TO-FACE TIME SPENT THAT DAY, WHICH TIME THRESHOLDS SHOULD BE USED? 2020 OR 2021 OR OTHER. CMS IFC INDICATED WOULD DETERMINE.

CMS has clarified that providers should use the times listed in the CPT 2020 book, as it was too confusing to have different times for CMS and all others. This will most likely change in 2021, but for now use the times listed in the CPT for all payors.

IF IT'S BILLED BY MDM, BUT THE VISIT WAS REALLY SHORT, DO YOU OMIT THE TIME????

You can bill by either MDM or time, but you can document both. There is no written guidance saying that you can't document the time in each encounter. This would be provider preference.

CLARIFICATION TO MDM VS TIME, DO YOU NOT WRITE TIME AT ALL SO THEY CAN'T AUDIT AND DOWN CODE?

The guidelines say MDM or Time, so as long as documentation support medical decision making and the provider can defend the choice, this shouldn't be an issue. This is provider choice. If you don't feel comfortable documenting time, then you can certainly bill by MDM for each visit and not record the time. Just remember that either is an option.

SO, YOU ARE SAYING FOR CERTAIN THAT MDM AND TIME (WITHOUT EXAM AND HPI) ARE THE BASIS FOR CHOOSING LEVEL OF SERVICE? OF COURSE STILL DOCUMENTING EXAM AND HPI NO MATTER WHAT QUANTITY OBTAINED.

Yes, great point. While history and exam are not considered in the leveling of the visit, they are clinically relevant in establishing medical necessity. A pertinent history and exam should always be documented for each visit.

ARE START AND STOP TIMES NECESSARY FOR TIME-BASED TELEMEDICINE VISITS OR TELEPHONE ONLY VISITS?

You can document either start and stop times or exact time spent on each visit. It is not acceptable to use a generalized time macro (eg "greater than 20 mins was spent…"), as these visits require exact time spent.

I'M TRYING TO FIND THE LINK IN CMS WHERE IT STATES THAT THEY REVISED THEIR TELEHEALTH POLICY BY ALLOWING MDM OR TIME

See Interim Final Comment (IFC) https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

CAN YOU BILL IF THE PHONE CALL OR VIDEO CALL IS LESS THAN 5 MINUTES LONG? OR DOCUMENTED AS LASTING ONLY 5 MINUTES? DOES IT HAVE TO BE 10 MINUTES MINIMUM?

No. The codes state "5 minutes (or more)" so the codes would not be applicable. Private insurance companies may have other guidelines, but for Medicare patients these visits are not billable. Calls of at least 5 mins are billable with proper documentation.

IS IT POSSIBLE TO HAVE A MAILING LIST THAT SENDS AN EMAIL WHEN THE TELEHEALTH POLICIES ARE UPDATED ON THE KZA WEBSITE? IT WOULD MAKE IT EASIER TO KEEP UP.

You can sign up for KZA Alerts by going to KarenZupko.com.