Billing & Coding FAQ

What are the major changes to the Medicare telehealth policies affected by the 1135 waiver?

The most important provisions for healthcare providers are:

I. The elimination of the requirement that the originating site must be a physician's office or other authorized healthcare facility; patient can be in their home or other care setting.
II. Non-enforcement of the established patient relationship requirement. HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
III. Non-enforcement of HIPAA regulations as it relates to the technology used to communicate with your patients. Audio-video is still required from a CMS perspective, however the waiver in Section 1135(b) specifically allows use of telephones that have audio-video capabilities to furnish telehealth during the COVID-19 public health emergency. For more information click here.

Given recent regulatory changes in response to the COVID crisis, is there any special requirements to purchase software or equipment?

No. However there are some limitations. Your practice needs to make a good faith effort to protect your patients by avoiding the use of public-facing technology such as Facebook Live, Twitch, TikTok or similar video communication applications. The waiver in Section 1135(b) specifically allows use of telephones that have audio-video capabilities such as FaceTime and also list other meeting-based software programs such as SKYPE and Zoom as acceptable.

Are the changes pertaining to telehealth limited to only care related to COVID-19 conditions?

No. The statutory provision expands telehealth flexibility without regard to the diagnosis of the patient.

This provision is to prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely. For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. You must document the medical necessity of the visit.

How does our practice bill for telehealth services? What can be expected for payment?

Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the place of service (POS) where the services would have normally taken place. Refer to the most updated list of Medicare approved codes available for download here. For commercial carriers, the CPT codes approved by most carriers are found in the CPT book under Appendix P. For many of the commercial carriers, they will require a GT or 95 modifiers it is important to check every insurance carrier site for specifics.

Medicare and commercial carriers pay the same amount for telehealth services as it would if the service were furnished in person.

Who are the eligible providers allowed to bill telehealth services under the COVID-19 waiver?

Physicians, nurse practitioners, physician assistants, certified nurse anesthetists, certified nurse midwives, clinical psychologists, licensed clinical social workers, physical therapists, occupational therapists, registered dietitians, and nutrition professionals. The ability to provide services are generally based on the scope of license of the provider, state regulations, and guidance on specific codes. For example, providers who are not eligible to provide E&M codes, there are other technology-based services available such as E-visits. For a full list of telehealth codes and descriptions as well as additional technology-based codes available, reference our Telehealth Billing Guidance Sheet. **LINK TO EXCEL DOCUMENT.**

CPT and Medicare codes relating to E-visits for other than those who bill EM:

Code	Description
98970 CPT Q2061 Medicare	Qualified non-physician healthcare professional online assessment and management established patient cumulative for 7 days: 5-10 min.
98971 CPT Q2062 Medicare	Qualified non-physician healthcare professional online assessment and management established patient cumulative for 7 days: 11-20 min.
98972 CPT Q2063 Medicare	Qualified non-physician healthcare professional online assessment and management established patient cumulative for 7 days: 21 minutes or more.

Are telephone calls covered under the new telehealth provisions?

Yes, but not for the list of telehealth codes. Those are a specific expanded benefit. Medicare came back then and allowed the telephone EM codes 99441-99443. Therefore if you cannot provide a service as audio/video listed under the telehealth benefit, you can then use the telephone EM code set.[1] Under Medicare, telephone calls are not part of the referenced telehealth provision, but it is part of a different benefit through a telephone evaluation and management codes 99441-99443 which are time-based codes.

For commercial payers we recommend you follow the audio-video guidance currently in place until notified otherwise by your carriers. Some carriers allow for telephone contact on specific types of benefit allowances. Always reference each carrier specifically for guidance. Sometimes an specific employer will allow the benefit which makes managing this information rather difficult.

With these notifications and subsequent provisions expressed as effective March 6, 2020 what is the expiration date?

The telehealth waiver will be effective until the declared public health emergency ends. There will likely be an official public notice similar to the enactment of these provisions. It will be important for your practice to be diligent in remaining informed on the latest guidance. As of the update of this document in December 2020, the PHE still remains and each carrier has moved the target end date farther out into 2021.

Are Medicare services Virtual check-ins and e-visits different from telehealth?

Yes. A virtual check-in HCPCS code G2012 is a brief (5-10 min) communications that mitigate the need for an in-person visit and can be conducted by telephone or email, whereas a visit furnished via Medicare telehealth is treated the same as an in person visit and can be billed using the code for that service. An e-visit CPT codes 99421-99423 is when a patient communicates with their doctors through online EHR portals requesting evaluation and management of a condition or concern.

How do we choose the level of evaluation and management codes when billing via telehealth?

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[1] 99441-99443 Also requires that you be a provider approved to bill the EM code set. Such as MD, DO, CNP, or PA as examples

Every visit should be documented in the same manner as you would if the services were provided in-person with the exception of the physical exam, which will be limited based on the service delivered as telehealth. (Note: Some exam elements may be measured and self-reported by the patient such as height, weight and in some instance blood pressure or pulse oximetry. For those patients who already have chronic conditions with equipment at home may self-report that information. Simply document this in the exam portion with a notation such as *"reported per patient as measured today on home equipment".)*

Providers will still need to document a relevant history (HPI, ROS and PFSH) and medical decision-making portion. Medical decision making is the assessment and plan which includes the clinical impression (diagnoses) and the treatment plan to address each diagnosis provided.

You may also choose to document and select the code based on time spent. In this situation, you must document the time with other clinical documentation to describe the encounter, however you do not have to meet the specification of the code otherwise through elements.

We also recommend you document how the telehealth encounter was conducted.

Are we permitted to notify our patients of potential telehealth benefits?

Yes. ***Medicare does state that providers should inform their patients that services are available via telehealth.*** We recommend you decide as a practice how to safely and effectively deliver telehealth services based on your specialty and patient population.

Can patients use their Health Savings Accounts (HSA) for telehealth services?

Yes. Section 3701 of the CARES Act allows a high-deductible health plan (HDHP) with an HSA to cover telehealth services ***prior to a patient reaching the deductible***. You may find a thorough listing of the key telehealth provision of the CARES Act from the American Telemedicine Association.

Didn't find your answer? Ask your questions.

As the crisis unfolds, you may have questions related to billing and coding. We invite you to submit your questions to Billing@VirtualPractices.org.

We will review these questions and answer them publicly for the benefit of the community.

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