COVID-19 Telehealth Coverage Changes
What You Need to Know

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On Tuesday afternoon, March 17, 2020, CMS issued guidance explaining its temporary changes to Telehealth Coverage to help address the COVID-19 emergency situation.

Note – While teleradiology is considered Telemedicine, for the purposes of the COVID-10 related coding and billing changes, teleradiology guidelines HAVE NOT CHANGED.

Key takeaways are:

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare **telehealth services** furnished to patients in broader circumstances.
- These visits are considered the same as in-person visits and will be paid at the facility rate.
- Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.
- To the extent that prior services required established relationships, CMS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
- This means that providers can provide Telehealth Visit services for new patients.

It is important to recognize that the allowance for these telehealth services is specific to Medicare and while states are encouraged to make changes to their individual Medicaid programs any changes to those programs would be made on a state-by-state basis. In addition, to date we have received nothing to indicate if any commercial carriers will be allowing reimbursement for these services.

Summary of Telemedicine Services

Telehealth Services

- Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person. **However, the in-person and selected areas limitations have been removed.**
- For Telehealth services (not telephone services) the provider must use a **"synchronous audiovisual link with patient", an active audio and video telecommunications system that permits real-time communication** between the distant site and the patient at home, such as FaceTime or Skype.
- The requirement for a prior relationship with the patient has been temporarily removed.
- The communication requirements have been relaxed to allow the use of everyday technology such as FaceTime or Skype.
- The HHS Director General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
- Code sets

99201	Office/outpatient visit new	99211	Office/outpatient visit established
99202	Office/outpatient visit new	99212	Office/outpatient visit established
99203	Office/outpatient visit new	99213	Office/outpatient visit established
99204	Office/outpatient visit new	99214	Office/outpatient visit established
99205	Office/outpatient visit new	99215	Office/outpatient visit established

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E-VISITS

- Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted **via a patient portal.**
- Services can be provided in all types of locations including the patient's home, and in all areas where 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 patient must verbally consent to receive virtual check-in services.
- The Medicare coinsurance and deductible would apply to these services.

Code Sets

- Online digital evaluation and management service - Established patient, 7 days, cumulative time during the 7 days
  - › 99421 5-10 minutes
  - › 99422 11-20 minutes
  - › 99423 21 or more minutes
- These codes are assigned based on the cumulative time total for the service provided.
- Documentation can be as simple as: Total cumulative time for the 7-day period ending on this date of service, including test orders, prescription generates, and all communication is XX minutes.
- **Medicare does have an established fee for these services.**

Telephone Evaluation and Management

- Services provided 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
- Code Sets
  - 99441 5-10 minutes of medical discussion
  - 99442 11-20 minutes of medical discussion
  - 99443 21-30 minutes of medical discussion
- This code set is billed per date of service and are based on the total time of the actual phone discussion.
- A sample time statement would be: Total time spent in medical discussion with the patient or guardian is XX minutes.
- Codes can be used for established patients who might have a new problem but are established with the practice.
- **CMS is finalizing for this interim ruling to recognize codes 98966-98968 and 99441-99443. CMS will provide separate reimbursement and relative value units (RVUs) for each code.**

Documentation

- Documentation must indicate if this is a **Telehealth (virtual), E-Visit or Telephone encounter**
- Documentation must include time
- Documentation requirements for these telehealth services remain the same and total time is the single most important element to be reported.
- Documentation should also clearly state the format used for the visit, discussion points, any medical decision making such as prescriptions or ordering of diagnostic testing, and any follow-up needed.

Telehealth Coverage Policies

The California Health Care Foundation provided an excellent resource and Fact Sheet from The Centers for Connected Health Policy that summarizes federal and state level developments on telehealth so far.

https://www.cchpca.org/sites/default/files/2020-03/CORONAVIRUS%20TELEHEALTH%20POLICY%20FACT%20SHEET%20MAR%2016%202020%203%20PM%20FINAL.pdf?_cldee=cGt yb2tlbkBjb21jYXN0Lm5ldA%3d%3d&recipientid=contact-7dc1ec15581ce51180f7c4346bac4b78-0e8cd3af692c4768b30909008c8d7fc4&utm_source=ClickDimensions&utm_medium=email&utm_campaign=Newsletter_2020_Q1 &esid=b9da63b8-7868-ea11-a811-000d3a1b1d16

For more information, and to read the full advice on coding the 2019 Novel Coronavirus (COVID-19), pleasevisit the CDC and WHO websites, respectively:

https://www.cms.gov/files/document/covid-final-ifc.pdf

https://www.cdc.gov/coronavirus/index.html

https://www.who.int/health- topics/coronavirus

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical- guidance-managementpatients.

html https://www.cms.gov/newsroom/fact- sheets/medicare-telemedicine-healthcare-provider-fact-sheet

This educational guide was prepared as a tool to provide education for documentation and coding. It is not intended to affect clinical treatment patterns. The material provided is for informational purposes only. Efforts have been made to ensure the information within this document was accurate on the date of distribution. Reimbursement policies vary from insurer to insurer and the policies of the same payer may vary within different U.S. regions. All policies should be verified to ensure compliance.

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