Coding and Billing for Telemedicine Services in the age of COVID-19 & Beyond:

Practical Tips for the Practicing Allergist

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Disclosures

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Overview

- Historical restrictions on coverage and reimbursement
- COVID-19's impact on telemedicine regulation & reimbursement
- Billing for virtual health services
- Importance of internal audits
- Future of telemedicine reimbursement post-PHE

Telemedicine coverage & reimbursement restrictions

- Geographic restrictions
  - Rural areas
  - Originating site requirements
- Coverage restrictions
  - Limited coverage for new patients
  - Narrow telehealth networks
- Payment restrictions
  - Lower reimbursement vs in-person visits
  - Payment parity mandated by only a handful of states
- Regulatory variability
  - Plan, Carrier, State

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Billing & coding for common virtual health services

- Virtual check-in
- Remote evaluation of video/image
- Telephone visit
- E-visit
- Standard E/M

Virtual check-in:

G2012
Usual POS
No modifier

$14.66 / $13.26
(non-facility/facility)

- Brief (5-10 min) synchronous audio or audio-video interaction between patient and provider (MD, DO, PA, NP) to determine need for further evaluation
- Cannot arise from a previous E/M visit in the last 7 days or result in an E/M visit in the next 24 hrs (or next available)

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Virtual check-in:

G2252
Usual POS
No modifier

$26.87 / $25.47
(non-facility/facility)

- Intermediate (11-20 min) synchronous audio or audio-video interaction between patient and provider (MD, DO, PA, NP) to determine need for further evaluation
- Cannot arise from a previous E/M visit in the last 7 days or result in an E/M visit in the next 24 hrs (or next available)

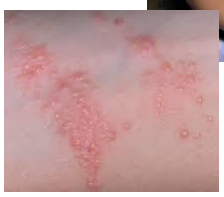
NEW in 2021: This code is not subject to Section 1135 PHE waivers, and will survive the public health emergency, regardless of patient location.

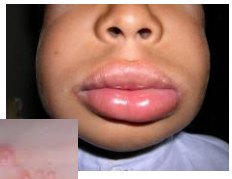
Remote evaluation of patient-submitted images & video:

G2010
Usual POS
No Modifier

$12.21 / $9.42
(non-facility/facility)

- Provider reviews and provides guidance on images or video submitted by established patient (rash, angioedema, barky cough, etc.)





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Telephone visit:

99441-3
Usual POS
modifier -95

$56.88-$131.55;
$36.29-$100.84
(non-facility/facility)

- Synchronous audio-only evaluation and management initiated by patient and performed by provider (MD/DO, PA, NP) – during PHE, OK for New Patient
- Not arising from E/M in last 7 days or resulting in new E/M asap
- Time-based
  - 99441: 5-10 min
  - 99442: 11-20 min
  - 99443: 21-30 min
- CMS & Aetna reimbursement temporarily equivalent to 99212-4
- Cigna, Humana, UHC permitted billing for telephone visits as face-to-face E/M codes during PHE telehealth expansion

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CMS reimbursement for telephone-only evaluation will expire post-PHE – plan to use G2012 & G2252 (virtual check-in) instead

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Digital health evaluation (e-visit):

99421-3
Usual POS
No modifier

$15.00-$47.46;
$12.91-$41.17
(non-facility/facility)

- Non face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office
- Not arising from E/M in last 7 days or resulting in new E/M asap
- Using a secure platform (ie: HIPAA-compliant patient portal or secure email)
- Bill only once in a 7-day period, based on cumulative time spent in review/research/response
  - 99421: 5-10 min
  - 99422: 11-20 min
  - 99423: 21 or more min
- If results in E/M within 7 days of initiation, roll time into E/M level instead of billing e-visit separately

New patient E/M:

99201-5
Usual POS*
Modifier -95

$73.97-$224.36;
$49.90-$186.68
(non-facility/facility)

* Use POS "02" for Tricare & Aetna

- Must be delivered via synchronous audio-video connection
- Exceptions include Cigna, Humana, UHC, which are temporarily permitting audio-only E/M
- Bill based on time (total time spent by clinician on day of service, rather than only on counseling/coordination of care) or medical decision-making (MDM)
  - 99202: 15-29 min
  - 99203: 30-44 min
  - 99204: 45-59 min
  - 99205: 60-74 min
  - 99417 (CPT prolonged service, in 15 min increments): 75-89 min
  - G2212 (CMS prolonged service): 89-103 min

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Established patient E/M:

99211-5
Usual POS*
Modifier -95

$23.03-$183.19;
$9.07-$147.95
(non-facility/facility)

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- Must be delivered via synchronous audio-video connection
- Exceptions include Cigna, Humana, UHC, which are temporarily permitting audio-only E/M
- Bill based on time (total time spent by clinician on day of service, rather than only on counseling/coordination of care) or medical decision-making (MDM)
  - 99211: 5-9 min
  - 99212: 10-19 min
  - 99213: 20-29 min
  - 99214: 30-39 min
  - 99215: 40-54 min
  - 99417 (CPT prolonged service, in 15 min increments): 55-69 min
  - G2212 (CMS prolonged service): 69-83 min

Importance of internal audits

- Obtain consent
  - Patient must be informed that service will be billed, and agree to service
  - Consent must be documented in the record
    - Check with your state
- Use the correct POS and modifier
  - Some payers only pay with parity to in-person rates when using POS "11" and modifier -95 or -GT
  - Others mandate the use of POS 02 to signify telehealth services
- Check your fee schedule
  - Have you updated your telephone visit charges to be at least equal to your 99212-4 reimbursement?
- Stay up to date
  - Guidelines are in flux. Stay on top of changes and expiration dates.

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Future of telemedicine reimbursement

- **Telehealth expansion waivers won't last forever**
  - But we also can't go back to baseline
- **CMS moving to make some PHE-related changes permanent**
  - Adding services permanently to telehealth list
  - Lifting originating site requirements and geographic restrictions will be tricky, and may require Congressional intervention
- **Parity**
  - Increased coverage parity is likely, as patients will demand the ability to receive telehealth from established physicians
  - Payment parity will be more difficult to achieve, given concerns over over-utilization, fraud, and budgeting
    - If achieved, will likely be bundled with patient cost-share to limit over-utilization
- **Technology**
  - Prepare now for secure, end-to-end encryption and HIPAA-compliance

Impact of PHE on telemedicine expansion

- **Coverage parity**
  - ✓ New patients
  - ✗ Telephone care
  - ✓ Virtual check-in, Remote evaluation, E-visit
  - ✗ Out of network coverage
- **Payment parity**
  - ✓ CMS → Private payers
  - ✗ Waiver of cost-share
- **Regulatory relaxation**
  - ? Lifting of geographic restrictions
  - ? Practice across state lines
  - ✗ HHS enforcement discretion
- **Capture previously lost revenue from uncompensated care**

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Final Takeaways

- The COVID-19 public health emergency has significantly accelerated the pace of telehealth expansion in the United States.
- Gaining familiarity with a handful of codes and modifiers will enable you to bill for a broad spectrum of telehealth services.
- Periodic audits of your own coding and reimbursement can ensure that any billing mistakes are corrected as early as possible.
- Telehealth reimbursement policies are in a state of flux, so it is important to stay abreast of federal-, state-, and payer-specific guidelines to ensure you are compensated appropriately.

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