ASRS American Society of Retina Specialists

Guidance on Medicare Telehealth and Other Remote Services During the COVID-19 Public Health Emergency

As of March 1, 2020, the Centers for Medicare & Medicaid Services (CMS) will pay clinicians to provide services using various forms of communication technology during the COVID-19 Public Health Emergency (PHE) to all Medicare patients, regardless of their diagnosis or condition, located anywhere across the country including in a place of residence. On March 30, CMS announced additional remote services that may be furnished during the PHE via telehealth, phone calls and remote patient monitoring technology for individuals with acute and chronic conditions, even those unrelated to COVID-19.

The information below applies to Medicare and is only effective during the COVID-19 PHE. Private payers and state Medicaid plans have their own payment guidance and are not obligated to follow Medicare policies.

There are three main types of virtual services physicians and other qualified health professionals can provide to Medicare beneficiaries: Medicare telehealth visits, virtual check-ins and e-visits.

Medicare Telehealth Visits

Medicare telehealth visits are real-time interactions between a new or established patient and their physician or other qualified health professional. The examination and communication are the same as when the service is rendered face-to-face. These visits must be audio and video however the Medicare definition has been relaxed for the PHE to include even devices considered "phones" such as iPhones and tablets for use with Skype or FaceTime, but public facing video applications such as FaceBook Live or TikTok should not be used. In addition, penalties for HIPAA violations will be waived if services are delivered in good faith through these communications technologies during the PHE.

<u>Coding Medicare Telehealth Visits</u>

Currently, CMS requires that claims for Medicare telehealth services include the Place of Service (POS) code 02, which is specific to telehealth services. When billing for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the PHE, report POS as if the service was furnished in person as it would have been before the PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. This will allow CMS systems to make payment at the same rate as it would have been paid if the services were furnished in person. CMS is not requiring the "CR" modifier on telehealth services unless consistent with current rules for traditional telehealth services.

- During the PHE, office/outpatient E/M selection when furnished via telehealth can be based on medical decision-making (MDM) or time with the time corresponding to the evaluation and management times associated with the E/M on the day of the encounter.

- During the PHE, CMS removed all requirements regarding documentation of history and/or physical exam in the medical record for these services.
- Report the E/M code that best describes the nature of the care provided. An updated list of 2020 Medicare telehealth services are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
- Medicare Telehealth visits are paid under the Medicare Physician Fee Schedule (PFS) at the same rate that ordinarily would have been paid under the PFS for an in-person visit.
- A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233)
- Eye codes 92002, 92004, 92012 and 92014 cannot be used to report telehealth visits.

Non Telehealth Services (Remote Non Face-to-Face Services)

Virtual Check-Ins

Medicare pays for services not considered telehealth but provided via telecommunications technology such as remote monitoring, interpretations of diagnostic tests and check-ins. These services would typically not have been an office visit or other in-person service. Virtual check-ins are brief communications (5-10 minutes) with an MD/DO or other qualified health professional using technology (including audio-only) and are used for established patients.

- During the PHE, clinicians can provide virtual check-in services that do not result in a visit, including a telehealth visit, to both new and established patients.
- They can be documented by auxiliary staff under general supervision.
- Consent may be obtained at the time of service.

Coding

Virtual check-ins (CPT Codes 99421-99423; HCPCS codes G2061, G2062, G2010, G2012) can be billed if the service does not originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment. These visits may also include report evaluations of recorded video and/or images submitted by the new or established patient, HCPCS code G2010 should be used for this instance. While some code descriptors refer to “established patient,” during the PHE, in order to include all patients, CMS will not conduct review to consider whether those services were furnished to established patients.

Documentation

- Confirm the patient’s identity (name, date of birth, or other identifying information, particularly if you are not accessing the patient’s electronic or paper record).
- Obtain and document that verbal consent was obtained.
- Detail what occurred during the communication to establish medical necessity (e.g. description of the patient’s problem, details of the encounter).
- Document the total time spent communicating with the patient. If less than 5 minutes, do not submit G2012.

Telephone E/M Services

Despite the fact that certain telephone services are classified as E/M in coding, CMS considers these E/M services closely analogous to virtual check in services. Although typically "non-covered," on an interim basis during the PHE, CMS will pay for these codes for use by physicians and a broad range of clinicians to provide clinically appropriate services via telephone where two-way audio and video technology is not available such that the service does not qualify as a telehealth visit. CMS is providing separate payment for telephone Evaluation and Management services for new or established patients during the PHE for CPT codes 98966-98968 and 99441-99443. Even though code descriptors may indicate it is for established patients, CMS will not enforce that requirement.

Online Digital Services (E-Visits via Patient Portals) Expanded for Medicare patients Served by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

In 2019 CMS began payment for new online digital assessment services, also referred to as "E-Visits," for practitioners billing under the PFS for non-face-to-face, patient-initiated communications using online patient portals for established patients who require a clinical decision that otherwise typically would have been provided in the office.

On an interim basis during the PHE, practitioners in Rural Health Clinic (RHCs) and Federally Qualified Health Centers (FQHCs) may use e-visits when appropriate for both new and established patients, in the place of services that would have otherwise been furnished in person and reported and paid under established methodologies. CMS is expanding the services that can be included in the payment for HCPCS code G0071, and updating the payment rate to reflect the addition of these services. Specifically, CMS is adding the following three CPT 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.

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