TELEHEALTH SERVICES

You must use an interactive audio and video telecommunications system that permits real-time communication between you at the distant site, and the beneficiary at the originating site.

Transmitting medical information to a physician or practitioner who reviews it later is permitted only in Alaska or Hawaii Federal telemedicine demonstration programs.

CY 2019 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	G0406–G0408
Office or other outpatient visits	99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307–99310
Individual and group kidney disease education services	G0420–G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training	G0108–G0109
Individual and group health and behavior assessment and intervention	96150–96154
Individual psychotherapy	90832–90838
Telehealth Pharmacologic Management	G0459
Psychiatric diagnostic interview examination	90791–90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	90963

UPDATED MARCH 17TH 2020

TELEMEDICINE VISITS

This summary provides an overview of coverage for non-face-to-face patient visits through telehealth. Many payors, including the Centers for Medicare and Medicaid (CMS) are encouraging use of telehealth, as appropriate, to provide patient access options during the COVID-19 outbreak. **IF ENGAGED WITH A TELEMEDICINE VENDOR (*I.E. EXAM MED, AMWELL ETC)* PLEASE FOLLOW THE BELOW GUIDANCE AROUND CODING/BILLING SET UP:**

- **PLACE OF SERVICE CODE IS "02"**
  - ***PLEASE MAKE SURE THIS POS BUILT IN YOUR HOME SYSTEM***
- **MODIFIER 95 (USE FOR ALL PAYERS EXCEPT MEDICARE)**
  - ***PLEASE MAKE SURE THIS MODIFIER IS BUILT IN YOUR HOME SYSTEM***
- **AS OF TODAY MARCH 17TH, 2020 THE ESTABLISHED PATENT ONLY REQUIREMENT WAS LIFTED DURING THIS STATE OF EMERGENCY VIA CMS.**
- **THE VISIT DOES NOT HAVE TO BE JUST FOR COVID19 SCREENING/EXPOSURE ETC.**
- **THE LIST OF CODES THAT ARE APPROVED FOR TELEHEALTH ARE PROVIDED AS A SEPARATE ATTACHMENT**
- **DOCUMENTATION REQUIREMENTS REMAIN THE SAME FOR ALL SERVICES (IF IT APPLIED IN PERSON IT APPLIES VIA TELEHEALTH).**
- **DIAGNOSIS CODE(S):**
  - ***Diagnosis code(s) should reflect the assessment of the patient just like any other evaluation and management service. Additional guidance specifically around COVID 19 is below.***
- **MANY PAYORS ARE REDUCING AND OR WAIVING COPAYS DURING THIS PERIOD-COPAYS WILL BE COLLECTED ON THE BACKEND AFTER PAYOR ADJUDICATION**

Exposure to COVID-19
For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

Signs and symptoms
For patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
- R05 Cough
- R06.02 Shortness of breath
- R50.9 Fever, unspecified

Note: Diagnosis code B34.2, Coronavirus infection, unspecified, would in generally not be appropriate for the COVID-19, because the cases have universally been respiratory in nature, so the site would not be "unspecified." If the provider documents "suspected", "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, or Z20.828).

For additional questions please reach out to your Revenue Integrity contact-Thank you!

NORTHSIDE HOSPITAL

COVID 19 Coding Update

Virtual Check-In

G2012

Frequently Asked Questions (FAQs)

1. **What are Virtual Check-Ins**? Officially titled "Brief Communication Technology-Based Service, e.g. Virtual Check-In." Virtual Check-In is defined as "Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management (E/M) services, provided to an established patient, 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; 5-10 minutes of medical discussion)."
2. **What Modality is Allowed**? **CMS stated the code allows "audio-only real-time telephone interactions (Note: telephone calls that involve only clinical staff cannot be billed using HCPCS code G2012 since the code explicitly describes (and requires) direct interaction between the patient and the billing practitioner.)**
3. **Is There a Patient Co-Payment for Virtual Check-Ins**? Yes, as a Medicare Part B service, the patient is responsible for a co-payment for the service
4. I**s Patient Consent Required?** Patient consent is required for this service, due in part to the fact that there is a patient co-pay. CMS stated that written consent is not required; a practitioner can obtain the patient's verbal consent and note that in the medical record for each billed service (i.e. every time the patient wants to obtain a virtual check-in).
5. **Are There Any Patient Restrictions?** CMS limits this code to **established patients only**. CPT defines an established patient as one who has received professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years.
6. **Who Can Deliver Virtual Check-Ins**? Virtual Check-Ins can be delivered only by those practitioners authorized to furnish E/M services. This service is meant to describe, and account for the resources involved, when the billing practitioner directly furnishes the virtual check-in. **Accordingly, only physicians and qualified health care professionals are allowed to bill for this service.**
7. **Are There Any Frequency Limits?** There is no frequency limitation on this code.
8. **Are There Any Timeframe Limitations**?
    1. *If the Virtual Check-In originates from a related E/M service provided within the previous 7 days by the same physician or other qualified health care professional, then the service is considered bundled into that previous E/M service and G2012 would not be separately billable (provider liable). In that event, do not bill either the patient or the Medicare program for that code.*

COVID 19 Coding Update

2. *If the Virtual Check-In leads to an E/M service with the same physician or other qualified health care professional within the next 24 hours or soonest available appointment, then this service is considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable (provider liable). In that event, do not bill either the patient or the Medicare program for that code.*

9. **What are the Documentation Requirements?** There are no service-specific documentation requirements for Virtual Check-Ins (other than documenting the patient's consent, of course). Documentation for Virtual Check-Ins is consistent with the requirements for other Medicare covered physician services. (normal evaluation and management service).
10. **Are There Any Patient Location Requirements?** The patient need not be located in a rural area or any specific originating site. The patient can be at home. Virtual Check-Ins are not considered a Medicare telehealth service.
11. **What POS should be used? 12 HOME**
12. **What diagnosis code**? For patients presenting with any signs/symptoms and where a definitive diagnosis has *not* been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as: Cough (**R05**); Shortness of breath (**R06.02**) or Fever unspecified (**R50.9**). For cases where there is possible exposure to COVID-19, but the disease is ruled out, report code **Z03.818**, Encounter for observation for suspected exposure to other biological agents ruled out. For cases where there is an actual exposure to someone who is confirmed to have COVID-19, report code **Z20.828**, Contact with and (suspected) exposure to other viral communicable diseases. This code is not necessary if the exposed patient is confirmed to have COVID-19.

March 2020 RI FAQ

Telemedicine and Virtual (Telephone) Check-ins

***Updated 3/18/20 @3:30pm**

Q. What should be billed for Virtual (telephone) check-ins?
   A. G2012 should be used for Virtual check-ins.

Q. What should be billed for Telemedicine visits?
   A. Note the email sent on 03/17/2020 along with approved list of services and CPT codes sent on 03/17/2020

Q. Can G2012 be used when providing virtual check-ins for symptoms and diagnoses other than COVID-19 related?
   A. Yes, virtual check-in services can be provided for other, non-COVID related symptoms/diagnoses.

Q. POS 12 is not available in the system; will it be added?
   A. Yes, PBS and I.S. are working to load POS 12 for all practices.

Q. POS 02 is not available in the system, will it be added?
   A. Yes, PBS and I.S. are working to load POS 02 for all practices.

Q. Can G2012 be used for commercial payers as well?
   A. G2012 should be used for all payers.

Q. Can the virtual check in service be provided to new patients?
   A. Not at this time. CMS limits this code to **established patients only**. **SUBJECT TO CHANGE!**

Q. Can we use CPT codes 99441-99443?
   A. No. CPT codes 99441-99443 are not valued by CMS and should not be used.

Q. What needs to be loaded in the Practice's home systems?
   A1. Virtual (telephone) check-ins: HCPCS code-G2012 and POS 12. POS 12 will pull in patient's home address to box 32.
   A2. Telemedicine: POS 02 and modifier 95.

Q. Are providers expected to document Telemedicine services.
   A. Yes, they should document these services just as they would all other services as if the patient presented to them in the office. (i.e. examine the patient using technology and peripherals that are equal or superior to an examination done personally by a provider within that provider's standard of care).

Q. Are providers expected to document virtual (telephone) services.

A. Yes, they should document consent for the service and the nature of the conversation and any outcomes/follow ups.

Q. What is the difference between Virtual check-in (G2012) and Telemedicine?

A. G2012 is a telephone call based service **without** face-to-face visual. Telemedicine is a technology based service and must include technology such as ExamMed or AmWell **with** a face-to-face visual service.

Q. Is a consent required for Virtual Check-ins and Telemedicine, and if so what type of consent?

A. Yes verbal consent from the patient should be documented for both. Specific language will follow in the FAQ tomorrow.

Q. Are rules being built in RCx to fire for correct POS and modifiers or these services?

A. Yes.

Q. What is the correct naming conventions for POS 02 and POS 12?

A. 02=Telehealth and 12=Home

02	Telehealth	The location where health services and health related services are provided or received, through a telecommunication system. (Effective January 1, 2017)

12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.

Q. Should the ML modifier be applied for these services if a Mid-level renders the service?

A. Yes, practices should utilize the mid-level job aide and workflow for these services to include Rendering & Supervising fields and ML modifier as appropriate.