**Frequently Asked Questions about Documentation, Coding and Billing under the COVID-19 provisions**

1. Q: When can I start billing patients for telemedicine under the new rules?

   A: The rules, announced on March 17, 2020 are retroactive to services provided on or after March 6, 2020.

2. Q: If the patient is not in a rural area, and not in a qualified "originating site" can we bill for telemedicine?

   A: Yes, patients can be located in their own homes, or anywhere else, as long as the telemedicine encounter qualified with the rest of the provisions.

3. Q: I understand that Telemedicine is only covered when the provider is using synchronous telemedicine platform via a Real-Time Interactive Audio and Video Telecommunications System. If our practice does not have that technology, or a vendor, can we bill?

   A: A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. The waiver allows use of telephones that have audio and video capabilities (Smart Phones)

4. Q: What about HIPAA? My understanding is that the patient must sign an informed consent form for their visit. Is that true?

   A: Under the rules released on Tuesday March 17, 2020 by HHS the HIPAA requirements are not enforced. So, no it's not necessary. The regulation is found here

5. Q: Our organization has privacy restrictions and concerns about the use of provider's cell phones. Will there be exceptions to the HIPAA rules if we allow cell phones?

   A: During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.

6. Q: Our Administration is not convinced; how do we protect HPI?

   A: Providers that seek additional privacy protection for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into a HIPAA business Associate Agreement (BAA). Examples: Skype for Business, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet

7. Q: Who can provide Telehealth under the COVID-19 waivers?

   A: A range of providers, such as doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, licensed clinical social workers, registered dietitians and nutrition professionals will be able to offer **telehealth** to their patients. Recognized, Licensed providers may vary, check your State regulations. Physical therapists are not included as a provider type that can furnish telehealth as a covered service to Medicare beneficiaries under this legislation. Due to a number of questions related to this legislation, APTA issued a March 9 news advisory on telehealth.

   Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

   G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes

   G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes

   G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

8. Q: Our staff is doing triage on all calls before deciding if a provider needs to speak to the patient to do a remote visit. Who can bill for telemedicine under the COVID-19 rules?

   A: A range of providers, such as doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, licensed clinical social workers, registered dietitians and nutrition professionals will be able to offer **telehealth** to their patients. Recognized, Licensed providers may vary, check your State regulations

9. Q: What CPT codes can be billed for telehealth?

   A: Reimbursement will be allowed for any telehealth covered CPT code **even if unrelated** to treatment of a COVID-19 diagnosis, screen or treatment

   There are 101 CPT codes designated as eligible for telehealth payment.

   - Office or other outpatient visits
   - Subsequent hospital and nursing facility care visits
   - Psychotherapy
   - Health and behavioral assessment and interventions
   - End-stage renal disease services

10. Q: What diagnosis code should be reported?

    A: As always, your E/M codes must be supported by diagnosis codes that report symptoms or confirmed illness to establish the medical necessity of the service, and support the level of service. For patients under your care for chronic conditions that must be assessed, this is straightforward. For patients who have symptoms, just report the symptom codes.c

    The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient. This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will 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. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

11. Q: What diagnosis code should I report if the telemedicine "visit" is COVID-19 related?

    A: On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern. As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus.

    -U07.1, COVID-19 (test confirmed)

    -Without a positive test

    - Z71.84 Encounter for Health counseling related to Travel
    - Z71.1 Person with feared health complaint in whom no diagnosis is made

12. Q: Can Telemedicine visits be billed for new patients to our practice?

    A: The new rules do not enforce the established relationship requirement that a patient see a provider within the last three years. New Patients may be problematic when you have to document 3/3 elements (History, Exam and MDM) in order to bill a new patient code 99201-99205. Documentation to support the level of service, or **time**, must be considered.

13. Q: We have a patient portal, can we bill for communicating with patients via the portal?

    A: Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

Report **G2012** 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 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. Avg payment $13.35.

There are restrictions. A physician or other qualified health care professional conducts a virtual check-in, lasting five to ten minutes, for an established patient using a telephone or other telecommunication device to determine whether an office visit or other service is needed. The service may be provided when a related evaluation and management (E/M) service has not been provided in the previous seven days and it may not lead to an E/M service within the next 24 hours or soonest available appointment.

14. Q: How do I bill for e-visits?

A: In all types of locations including the patient's home, and in all areas (not just rural), 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 services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following 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.

15. Q: How can I bill for telephone calls by a physician without video capabilitiy?

A: **For calls without video capability, you can report:**

**99441** telephone evaluation and management service 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; ***5-10 minutes of medical discussion***

**99442** ***…*** 11-20 minutes of medical discussion

**99443** ***…*** 21-30 minutes of medical discussion

16. Q: How do I bill for a nonphysician telephone call without video capability?

    A: For telephone calls by a qualified nonphysician (licensed health care professional)

    **98966** Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment***; 5-10 minutes of medical discussion***

    **98967** … 11-20 minutes of medical discussion

    **98968** … 21-30 minutes of discussion

17. Q: What place of service should be on my claim?

    A: For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

18. Since we are reporting an E/M Code, how do we choose the level of service?

    A: Each visit should be supported by documentation, such as a SOAP note. The History should be taken by interviewing the patient and writing a History of Present Illness (HPI) and Review of Systems (ROS). Other Past, Family or Social history, as necessary, should be documented. The physical exam will not be possible beyond a statement of the patient's general appearance. The Medical Decision Making (MDM) should state the diagnosis or symptoms, tests ordered/reviewed and the level of risk based on treatment plan. Time can also be considered, if documented. The Level of Service can be based on either History and Medical Decision Making, or Time, whichever is more advantageous to the provider.

19. Q: Since we will be reporting outpatient E/M codes will the patient be responsible for paying a copay?

    A: Yes, but The HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to **reduce or waive cost-sharing** for telehealth visits paid by federal healthcare programs.

    The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.