There is a Pandemic! How to Get Paid for Non-Face-to-Face Services

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Healthcare providers and the population at large are concerned about safe access to care considering the COVID-19 pandemic. As a result, we have received many inquiries this week about how to bill for "telehealth" services.

Let's first address that true telehealth services have some pretty stringent requirements from CMS, including that most visits require the patient to go to an authorized originating site such as a hospital or FQHC to be evaluated by a provider at a distant site. This seems counter intuitive to the intent of social distancing.

The good news is, there are other communication-based technology services that do not have these stringent requirements AND are covered by most insurance plans and CMS. Here is what you need to know.

Telephone Services

AMA and CMS have established CPT and HCPCS codes for reporting evaluation and management services provided by phone. These codes are reported based on time, so rule number 1 – providers must document the time spent rendering the service. The rest of the rules can be seen in the code descriptions.

"*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 services provided within the previous 7 days not leading to an E/M service or procedure within the next 24 hours or soonest available appointment;*

99441 – *5-10 minutes of medical discussion*

99442 – *11-20 minutes of medical discussion*

99443 – *21-30 minutes of medical discussion'*

- The call must be initiated by the patient
- These can only be reported by providers licensed to render E/M services
- The patient must be established to the practice
- The visit can't be related to an E/M service provided in the last 7 days
- The visit can't trigger a face-to-face visit within 24 hours or the soonest available appointment

For Medicare patients, these services are reported with:

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*

- The rules for 99441-99443 apply
- In addition, "The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service."

Other Communication-Based Technology

Remember Meaningful Use and the requirement that providers establish a secure portal for communicating with patients? (I heard you all groan when I was typing that question.) Good news!! If your organization is successfully using your patient portal, there are codes that can be reported to be paid for the work done. Of course, there are requirements for these as well.

"Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;

99421 – *5-10 minutes*

99422 – *11-20 minutes*

99423 – *21 or more minutes*

- The serviced must be initiated by the patient
- These can only be reported by providers licensed to render E/M services
- The patient must be established to the practice, but the problem can be new
- If the work takes under five minutes, it is not reported.
- Time can't be counted twice or billed for under another, separate code.
- The time can't be related to an E/M service provided in the last 7 days
- If a separate E/M face-to-face visit or real-time virtual visit occurs within the seven-day period, then this online work is incorporated into the face-to-face visit and not separately reported.
- The time is cumulative over the 7 days and begins when the provider reviews the online generated inquiry

The work included in these services is:

- Review of patient record and data pertinent to assessment of the problem.
- Development of a management plan.
- Generation of a prescription or test order.
- Any subsequent online communication that does not include a separately reported E/M service.

For Medicare patients, report the codes above.

All the services we have discussed so far must be rendered by a physician or other QHP, but what about the work of qualified nonphysician health professionals? More good news…there are codes for that! Keep in mind the rules above when reporting these services.

"*Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;*

98970 – *5-10 minutes*

98971 – *11-20 minutes*

98972 – *21 or more minutes"*

The corresponding codes for Medicare have a slightly different code description.

"*Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days;*

G2061 – *5-10 minutes*

G2062 – *11-20 minutes*

G2063 – *21 or more minutes"*

At this time, CMS has not relaxed the requirements for telehealth visits provided to traditional Medicare patients, but the fact sheet released this week does address Medicare advantage plans separately. They state "Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth." Check with your carriers to get specific guidance about this.

New information is being reported daily in response to COVID-19, so stay tuned to information being provided by CMS about any possible relaxation in the requirements for traditional Medicare telehealth services.

There has been a lot of good news in this article, but in my opinion the BEST news is that these codes were not created in response to the COVID-19 pandemic. These were created over the last couple of years and are available to be reported all the time. If you weren't aware of them before, something positive came out of the corona virus…no more missed opportunity for the work your providers are doing.

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