



# CMS Revises Telehealth Services During COVID-19 Outbreak Physician Education – Revised 3/31/20

## **Purpose**

To provide Client managers and physicians with updated CMS guidelines for telehealth services as a result of the COVID-19 outbreak. CMS issued updated Guidance on March 30, 2020. Also included are coding guidelines and appropriate documentation recommendations for reporting these services.

## **Background**

Historically, the term “telehealth” referred to the CMS coverage policy regarding distant site practitioners who furnish covered services using interactive audio and video telecommunications systems that permit real-time communication between the provider at the distant site (POS 02) and a patient at the originating site. Qualifying originating sites were defined as counties outside a Metropolitan Statistical Area (MSA) and rural Health Professional Shortage Areas (HPSA).

## ***Changes Effective March 1, 2020***

On March 17, 2020, CMS issued **guidance on Secretary Azar’s waiver authority that broadens access to Medicare telehealth services**. Effective **March 1, 2020** and for the duration of the COVID-19 Public Health Emergency, CMS will:

- Waive geographic restrictions, meaning patients can receive telehealth services in non-rural areas;
- Waive originating site restrictions, meaning patients can receive telehealth services in their home;
- Allow use of telephones that have audio and video capabilities;
- Allow reimbursement for any telehealth covered code, even if unrelated to COVID-19 diagnosis, screening, or treatment; and
- Not enforce the established relationship requirement that a patient see a provider within the last three years.

## ***Updates Released March 30, 2020***

CMS issued further coverage and expanded guidelines regarding telehealth services to be followed during the public health emergency (PHE). This includes instruction on:

- Coverage of telephone (audio only) assessment and management services;
- Place of Service billing requirements; and
- Modifier use.

There are three types of virtual services physicians and other healthcare professionals can provide to Medicare beneficiaries:

- **Medicare Telehealth Visits**
- **Virtual Check-Ins**
- **E-Visits**



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In addition to the summary of the broadened access listed above, the information below provides more specific information on how the new CMS telehealth coverage policies affect the different types of Medicare telehealth services.

## Telehealth Visits

- Medicare will pay for telehealth visits at the same rate they would be paid if the services were furnished in person.
- The Originating Site Requirement is suspended – Patients can receive telehealth services at their home.
- The Rural Location Requirement is suspended – Telehealth services will not be limited to patients in rural areas.
- Prior relationship (e.g., established patient) requirement for Telehealth services has been waived.
- **Telehealth services reported with EM codes 99201-99215 require a face to face video connection method.**
  - The HHS Office of Civil Rights (OCR) is relaxing the restrictions on the type of audio-visual connection to allow Telehealth Visits using everyday communications technologies, such as FaceTime or Skype, regardless if those methods are HIPAA-compliant.
  - The technology used must be "non-public facing." Therefore, Facebook Live, Twitch, and TikTok would not be acceptable to the Office of Civil Rights.
  - CMS is not changing the list of distant site practitioners (subject to state law), which can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- **Telephone (audio only) assessments, CPT 99441-99443 are typically considered noncovered services by Medicare**
  - These codes will be covered for both new and established patients throughout the PHE.
- **Modifier 95** must be applied to claim lines that describe services furnished via telehealth.
- CMS is not requiring additional or different modifiers specifically associated with telehealth services furnished under these waivers.
  - Consistent with current rules, there are scenarios where specific modifiers are always required on Medicare telehealth claims:
    - GQ modifier required in cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii.
    - GT modifier is required when a telehealth service is billed under CAH Method II.
    - G0 modifier is required when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke.
- In response to concerns that providers have to charge cost sharing for telehealth visits due to anti-kickback rules, the HHS Office of Inspector General will not enforce this anti-kickback rule for any services paid by Medicare, Medicaid, or CHIP.



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- Providers can reduce or waive cost-sharing for Telehealth Visits without penalty, but they are also not required to do so.

### Place of Service (POS)

**NOTE: Initial CMS guidance instructed that all services furnished under telehealth were to be reported using POS 02. The updates released on March 30, 2020 are as follows:**

- The claim should reflect the designated Place of Service (POS) code that would have been reported had the service been furnished in person (eg, Office – 11; Other outpatient – 22)
  - This addresses site neutral payments as historically Medicare uses facility rates when services are furnished via telehealth
  - *Creation of new locations for telehealth or POS 02 are not necessary*

### Coding Guidance

- For many providers, telehealth services will consist of Evaluation and Management services.
  - Office or Other Out-Patient Visits:
    - New Patient - 99201-99205
    - Established Patient - 99211-99215
- The rules of the **global surgical package** still apply when determining if an Evaluation and Management CPT codes can be reported.
- Encounters must continue to support a “significant and separate” EM service.
  - The following services are not separately reportable:
    - Pre-procedural evaluation included in the RVUs for a procedure;
    - Required H&P;
    - Postoperative visits during the global period of a procedure (e.g., 10 or 90 days).
- Telephone Assessment and Management
  - Telephone services (audio only).
    - CPT 99441-99443

### Documentation Requirements

- In order to clearly identify these services, the provider should include **Telehealth** in the exam title and specify the platform used to communicate with the patient.
  - **Specifically, if the encounter was a TELEPHONE service or an AUDIO-VIDEO service as these are reported differently.**
  - *Exam – Established Patient Telehealth encounter via audio and video enabled Skype call.*
- Telephone services are reported based on time of medical discussion.
  - The duration of the call should be included in the documentation.
- It is recommended that the provider document that the telehealth service was furnished during the COVID-19 Public Health Emergency period.
- Providers should continue to document the key component elements required to report EM services in the patient medical record to support the billing of these services.



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## Virtual Check-In

- A Virtual Check-In is a brief communication initiated by the patient with a practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed.

## HCPCS Coding

HCPCS Code	HCPCS Description
G2012	Brief communication technology-based service provided to an established patient; 5-10 minutes of medical discussion
G2010	Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with the patient within 24 business hours

## Coding Guidance

- Virtual Check-In's can occur regardless of if the patient is in a rural area.
- Patients can communicate with their practitioner using a broad set of communication methods regardless of audio-visual capabilities, including telephone or other communication technologies.
  - The practitioner can respond to the patient's concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.
- During the PHE, Virtual Check-In's are available to both new and established patients
- Service can be two-way audio only, real-time telephone interaction, or enhanced with video (G2012)
- Provider must review video/images submitted by patient and provide the patient an evaluation in the form of a 5-10-minute discussion (G2010)
- **Can only be reported if the encounter does not originate from a related EM service within the previous 7 days by the same physician or other QHP and does not result in a visit, including a telehealth visit (EM code)**
- Requires interaction between the patient and billing provider
  - Phone calls which involve clinical staff time is not billable with G2012
- Verbal consent must be obtained from the patient

## Documentation Requirements

- Patient consent must be documented in the patient record prior to the patient using the service.
  - Consent can be documented by auxiliary staff under general supervision
- CMS is not requiring any other service specific documentation requirements, only that it be medically necessary and reasonable.



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## E-Visits

- An E-Visit is a virtual evaluation and management service. E-Visits are different than Telehealth Visits because they must occur through an online patient portal.

## CPT/HCPCS Coding

CPT Code	CPT Description
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	...11-20 minutes
99423	...21 or more minutes

Due to the concern from CMS about the use of the term “evaluation and management” in the definition of the online digital codes for qualified nonphysician healthcare professionals, G codes were finalized for use in 2020 with the term “assessment” used in place of “evaluation and management.”

Report to Medicare as follows:

CPT Code	CPT Description
G2061	Qualified nonphysician healthcare professional online assessment, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
G2062	...11-20 minutes
G2063	...21 or more minutes

## Coding Guidance

- Patient must initiate the E-visit.
- During the PHE, this service is available to new and established patients.
- The patient does not have to be located in a rural area.
- E-Visits can also occur in the patient’s home.
- Services must be provided via email or through a portal on the provider’s website
- Based on cumulative time - Only billable once per 7-day period
- Clinical staff time is not calculated into the overall time reported
- Do not bill E-Visit services if total time is less than 5 minutes
- Cannot be billed on the same date as other established patient visit codes by the provider
- An EM service must be performed by provider. *They must evaluate, assess, and manage the patient, not simply communicate test results or schedule appointments.*

## Documentation Requirements

- The provider must keep a permanent record of the encounter, either electronically or on paper.
- The communication must comply with the provisions of HIPAA.



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## Resources

CPT® Professional Edition 2020

HCPCS Level II 2020

[CMS Medicare Telehealth FAQs 03172020](#)

[CMS Provider Fact Sheet Telemedicine 03172020](#)

[AMA Quick Guide to Telemedicine](#)

<https://www.cms.gov/files/document/covid-final-ifc.pdf>

## Revision History

03/18/2020 – Created Document

03/23/2020 – Revised; added information regarding modifier CR and POS 02.

03/31/2020 – Revised; Updated to reflect CMS guidance issued 3/30/2020; Added additional documentation guidance; Added Resource link to 3/30/2020 CMS release