COVID-19
Telehealth Coding

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Document

- The guidelines and rules for documentation are the same as before the crisis.
- I would advise if you are providing a telehealth visit, documentation should indicate the encounter is a telehealth visit
  - This is for your knowledge, the patient, and the payer.
- Components required for a specific CPT code are still required.

Diagnosis coding
(Per CMS and the CDC)

- Z20.828 Exposure to a person with confirmed COVID-19
  - Contact with and (suspected) exposure to other viral communicable diseases.
- Z03.818 Possible exposure to COVID-19 , rule out
  - Encounter for observation for suspected exposure to other biological agents ruled out
- J12.89 Other viral pneumonia
    - B97.29 – Other coronavirus as the cause of diseases classified elsewhere
- J40 Bronchitis, not specified as acute or chronic
    - B97.29 – Other coronavirus as the cause of diseases classified elsewhere

Diagnosis coding
(Per CMS and the CDC)

- J22 Unspecified acute lower respiratory infection
  - B97.29 Other coronavirus as the cause of diseases classified elsewhere
- J98.8 Other specified respiratory disorders
  - B97.29 other coronavirus as the cause of diseases classified elsewhere
- J80 Acute Respiratory distress syndrome
  - B97.29 Other coronavirus as the cause of diseases classified elsewhere

Diagnosis coding
(Per CMS and the CDC)

- U07.1 – COVID-19
- Emergency code established by WHO for use during this public emergency. Effective date April 1, 2020.

Procedure Codes

- Face to face encounters
- Telehealth Visits
- Online digital evaluation and management services
- Telephone Calls

Face to face encounters

- Evaluation and Management Codes (99201-99215) (99241-99245)
  - Requires the key components to support the level of care.
  - New patient – History, exam and medical decision making
  - Established patient – History OR exam and medical decision making
  - Time – if more than 50% of the encounter is in counseling and coordination of care
  - Key components to document for time:
    - Total time spent with patient
    - Percentage covering counseling and coordination of care
    - Details of the encounter.
  - Prolong services
    - With the patient face to face
    - Without the patient - only provider time not staff time

Telehealth

- Two guidelines – CMS and private payers
  - CMS – restrictions have been lifted regarding place of service for the patient and for the provider.
  - Telehealth is currently defined as any having audio and video capabilities that are used for two-way, real-time interactive communication.
  - Definition for telehealth applies to any services historically covered by Medicare, which are listed by CMS.
  - Appendix P of the CPT 2020 book also has a list of approved telehealth codes
  - Place of service is designated as 11 as of March 31. This is temporary per CMS
  - Modifier 95 is used to indicate place of the service is a telehealth encounter.
  - Modifier GT may also be used instead of modifier 95.
  - Patient permission for telehealth should be documented.
  - Document time if using time to support level of service.

Telehealth

Private Payers

- Following CMS Guidelines
- Have their own sets of codes that are payable
- Some are waiving the co-pays for telehealth for a period of time

Telehealth Codes

- Most common codes for Allergists:
  - 99201-99215
    - CMS indicates by waiver 1135 that there should be an established relationship with the patient to provide telehealth services
    - HHS will not be conducting audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
    - Key components would need to be documented to provide a specific level of care
    - Time may be used to support the level of care

Telephone Calls

- CPT 99441-99443
  - CMS will pay for telephone calls without video capabilities as of March 30.
  - May be used for new and established patient visits during the public health emergency
  - These are not consider telehealth codes. Do not use 95 modifier.
  - Interim work RVU:
    - 99441- .25 5-10 minutes
    - 99442 - .50 11-20 minutes
    - 99443 - .75 21-30 minutes
    - These are time driven codes - time must be documented

Virtual Check in (CMS)

- May only be reported when the billing practice has an established relationship with the patient.
- Individual service should be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- G2012 – Brief communication technology-based service 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 within the next 24 hours or soonest available appointment – 5-10 minutes

Virtual Check in (CMS)

- G2010 – Remote evaluation of recorded video and/or images submitted by an established patient (E.g., store and forward) including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service within the next 24 hours or soonest available appointment.

E visits

- 99421- 99423 Online digital evaluation and management services 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

Example of E visit 99421-99423

- Pt is on immunotherapy and is receiving their allergy injections at their primary care office. The patient has been educated and knows how to use the patient portal. The patient sends an email via the patient portal wanting to know what to do since the primary care office is not administering injections at this time. The patient is due for another allergy injection in two weeks. The physician and/or mid level provider emails the patient back stating the patient may pick up their vials and come to the allergist's office for administration of the injection. Total time spent 7 minutes. Document the total time spent and charge 99421.

Example of E visits 99421-99423

- Patent is seen and provided an Rx for their allergies and asthma. The patient is educated about using the patient portal to message with any questions or issues. 10 days later the patient messages the one of the prescriptions is causing intolerable side effects. The physician messages the patient asking for symptoms and asks if the problem the patient was originally evaluated for have improved, remained the same or worse. The patient returns a message stating the symptoms are better but side effects cannot be tolerated. The physician advised to continue with current medications for one more day to see if side effects subside. Patient emails back the following day that side effects are not better. The Physician calls in a new RX and notifies patient. The email exchange was done over a two day period with a total physician time of 12 minutes. Document the time spent and charge 99422.

Additional E Visits - CMS

- G2061-G2063 – Qualified non-physician healthcare professional assessment and management service
- Same time as 99421-99423
- May use online patient portals
- Initiated by the patient
- G2061-G2063 may be used by providers who aren't qualified to bill evaluation and management codes – i.e, dietitians, physical therapists, etc.

Telephone Calls

- 99441-99443 Non face to face telephone calls
  - 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
  - 99441- 5-10 minutes
  - 99442- 11-20 minutes
  - 99443 – 21 minutes or more
  - These codes may be paid by third party payers but are not covered by CMS.

Summary

- Check with your payers on their website for guidance
- Patients may have a co-pay or the co-pay may be waived
- Patients may be responsible for services – if so make sure there is a signed notice prior to the visit.
- Most payers (not all) want place of service “02”
- Payers vary on whether to use GT or 95 for the modifier

Questions

- Thanks for listening