Documentation, Billing and Coding Guidance to Providers for Telehealth Services

March 19, 2020

The following guidance has been compiled by New England Quality Care Alliance (NEQCA) and is based on the most current information available at the time of publication. NEQCA is not responsible for any issues related to billing and reimbursement.

In response to the Coronavirus outbreak, the Federal government has expanded access to telemedicine in Medicare, and Massachusetts Governor Charlie Baker has also ordered expansion to telehealth services access in Massachusetts. NEQCA is providing this update to assist our providers with documentation, billing and coding of services provided via telehealth. Please be advised that you should also refer to any communications received from Medicare and your local insurance carriers for the most updated guidance on documentation, coding and billing.

Commercial Payers

The Commonwealth of Massachusetts has issued Bulletin 2020-04 to the Commercial Health Insurers, Blue Cross and Blue Shield of Massachusetts and Health Maintenance Organizations that is intended to expand the use of telehealth services by in-network providers to treat medically necessary health conditions for all covered health services to help impede the transmission of Coronavirus by reducing the need for in-person treatment. This bulletin states in part that each Carrier should instruct its in-network providers to follow these standards in order to deliver medically necessary care via telehealth:

- For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service;
- For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service;
- Prior to each patient appointment, the provider must ensure that the provider is able to deliver the services to the same standard as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access);
- If the provider cannot meet appropriate standard of care or other requirements for providing requested care via telehealth, then the provider must make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care;
- To the extent feasible, providers must ensure the same rights to confidentiality and security to a patient as provided in face-to-face services and must inform members of any relevant privacy considerations prior to providing services via telehealth;
- Providers must follow consent and patient information protocols consistent with those followed during in-person visits;
- Providers must inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site);
- Providers must inform the patient of how the patient can see a clinician in-person in the event of an emergency or otherwise.

The Medical Group Management Association (MGMA) has this to say about telehealth services documentation best practices:

"*Documentation requirements for a telehealth service are the same as for a face-to-face encounter. The information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.*"

Reimbursement and Coding

Bulletin 2020-04 further states that carriers must reimburse providers for services delivered via telehealth at least at the rate of reimbursement that the carrier would reimburse for the same services when provided via in-person methods. The bulletin also directs insurance carriers to present clear communication materials to in-network providers to explain how to submit claims of reimbursement for services provided via telehealth. Once the carriers have provided final guidance, NEQCA recommends that providers consult the CPT coding manual for details of the documentation requirements of the CPT code submitted. Be sure to include documentation of the time spent during the encounter and indicate that the service was provided through telehealth.

Meanwhile, the American Medical Association (AMA) on March 18, 2020 released this guidance for visit coding. (Click here for full AMA article.)

Telehealth Visits

Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M).
CPT Code 99201-99205 (POS 02 for Telehealth, Modifier 95 (Commercial Payers)) – Office or other outpatient visit for the evaluation and management of a new patient
CPT Code 99211-99215 (POS 02 for Telehealth, Modifier 95 (Commercial Payers)) – Office or other outpatient visit for the evaluation and management of an established patient
*A list of all available codes for telehealth services can be found on the CMS website.

Online Digital Visits

Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (**via patient portal, smartphone**).
CPT Code 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
CPT Code 99422 – 11-20 minutes
CPT Code 99423 – 21 or more minutes

Medicare

A Centers For Medicare and Medicaid Services (CMS) fact sheet dated March 17, 2020 announced that "the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility." The fact sheet states that under a new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Medicare beneficiaries will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves and others at risk.

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries: Medicare telehealth visits, virtual check-ins and e-visits. Details on the requirements for these visits can be found in the CMS fact sheet. Here is a chart summary of the Medicare billing codes:

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: 99201-99215 (Office or other outpatient visits) G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recroded video and/or images submitted by an establish patient.	HCPCS code G2012 HPCPS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal	99421 99422 99423 G2061 G2062 G2063	For established patients.

Coding Intel has released a chart in this article showing Medicare reimbursement and RVU information for the on-line digital evaluation codes.

Massachusetts Medicaid Program – MassHealth

MassHealth issued All Provider Bulletin 289 to address coverage and reimbursement policy for services related to Coronavirus Disease 2019. The policy states that MassHealth will permit qualified providers to deliver clinically appropriate, medically necessary MassHealth-covered services to MassHealth members via telehealth (including telephone and live video). MassHealth is not imposing specific requirements for technologies used to deliver services via telehealth and will allow reimbursement for MassHealth covered services delivered through telehealth so long as such services are medically necessary and clinically appropriate and comport with the guidelines set forth in Appendix A of the bulletin. Providers are encouraged to use appropriate technologies to communicate with individuals and should, to the extent feasible, ensure the same rights to confidentiality and security as provided in face-to-face services. Providers must inform members of any relevant privacy considerations.

In the bulletin appendix, Masshealth provides these documentation requirements:

- For an initial appointment with a new patient, the provider must review the patient's relevant medical history and any available medical records with the patient before initiating the delivery of the service.

- For existing provider-patient relationships, the provider must review the patient's medical history and any available medical records with the patient during the service.

- Prior to each patient appointment, the provider must ensure that the provider is able to deliver the service to the same standard of care and in compliance with licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access) using telehealth as is applicable to the delivery of the services in person.

- If the provider cannot meet this standard of care or other requirements, the provider must direct the patient to seek in-person care. The provider must make this determination prior to the delivery of each service.

Rates of payment for services delivered via telehealth will be the same as rates of payment for services delivered via traditional (e.g., in-person) methods set forth in the applicable regulations. Providers must include Place of Service Code 02 when submitting a claim for services delivered via telehealth. Further, beginning April 1, 2020, Masshealth will reimburse for clinically appropriate, medically necessary telephone evaluations through the following CPT codes for physicians: 99441, 99442, 99443.

ICD-10 Diagnosis Coding

The Centers for Disease Control and Prevention (CDC) issued IDC-10 coding guidelines for health care encounters related to the 2019 novel coronavirus (COVID-19) on February 20, 2020 in a document titled "ICD-10-CM Official Coding Guidelines – Supplement." Here is a summary of the CDC guidelines:

General Guidance

Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes J12.89, Other viral pneumonia, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Acute Bronchitis
For a patient with acute bronchitis confirmed as due to COVID-19, assign codes J20.8, Acute bronchitis due to other specified organisms, and B97.29, Other coronavirus as the cause of diseases classified elsewhere. Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using code J40, Bronchitis, not specified as acute or chronic; along with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Lower Respiratory Infection
If the COVID-19 is documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, this should be assigned with code J22, Unspecified acute lower respiratory infection, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere. If the COVID-19 is documented as being associated with a respiratory infection, NOS, it would be appropriate to assign code J98.8, Other specified respiratory disorders, with code B97.29, Other coronavirus as the cause of diseases classified elsewhere.

ARDS
Acute respiratory distress syndrome (ARDS) may develop in with the COVID-19, according to the Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (COVID-19) Infection. Cases with ARDS due to COVID-19 should be assigned the codes J80, Acute respiratory distress syndrome, and B97.29, Other coronavirus as the cause of diseases classified elsewhere.

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."