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Coding update on CMS reimbursement for audio-only telephone E/M services

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On March 30, 2020, CMS released a 221-page interim final rule providing new regulatory relief and policy changes related to COVID-19.

While the FMA is still reviewing the regulation and its implications, it includes several developments worth sharing:

First, Medicare will begin reimbursing for audio-only telephone E/M services using CPT codes 99441-99443. These telephone-specific E/M CPT codes have existed for years but were previously considered non-covered services.

For these codes, for the duration of the PHE for the COVID-19 pandemic, CMS will pay for these services using the RVU values previously recommended by the RUC. In line with these recommendations, CMS has finalized

- 0.25 for CPT code 99441
- 0.50 for CPT code 99442
- 0.75 for CPT code 99443.
- In addition, CMS is finalizing the RUC-recommended direct PE input of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code.

a work **RVU of 0.25 for CPT code 99441, 0.50 for CPT code 99442,** and **0.75 for CPT code 99443**. In addition, CMS is finalizing the RUC-recommended direct PE input of 3 minutes of post-service RN/LPN/MTA clinical labor time for each code. As a reminder, the Medicare conversion factor is established at $36.09.

Information on how to **bill for these and other telehealth codes, provided by the AMA, is available here.**

Note: Other E/M service codes (e.g., 99211-99215) continue to require both audio and video capabilities.

CMS has also recently announced several additional changes related to telehealth. A high-level summary of this information is available below:

- -CMS will now pay for more than 80 additional services when furnished via telehealth. These include emergency department visits, initial nursing facility and discharge visits, and home visits, which must be provided by a clinician that is allowed to provide telehealth.
- CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health. During the pandemic, individuals can use commonly available interactive apps with audio and video capabilities to visit with their clinicians.
- Home health agencies can provide more services to beneficiaries using telehealth, so long as they are part of the patients' plans of care and do not replace needed in-person visits as ordered on the plans of care.
- Hospice providers can also provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so.
- If a physician determines that a Medicare beneficiary should not leave home because of a medical contraindication or due to suspected or confirmed COVID-19, and the beneficiary needs skilled services, he or she will be considered homebound and qualify for the Medicare Home Health Benefit. As a result, the beneficiary can receive services at home.
- Virtual check-in services, or brief check-ins between a patient and his or her doctor by audio or video device, could previously be offered only to patients who had established relationships with their doctors. Now, doctors can provide these services to both new and established patients.
- Clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry.

More Information:

The **Fact Sheet and announcement from CMS are available here,** along with additional information.

We will share more information as we continue to analyze these polices. Please visit the **Coronavirus Resource Center** on our website or contact us at **membership@FLmedical.org** if you have any questions.

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