Craneware®

Non-Face to Face Services FAQ

Hospital Providers – those who bill on a UB04 (or its electronic equivalent)

1. **Can hospitals bill telehealth services on a UB04 claim type? Is there a technical charge that hospitals can bill on a UB04 claim when a physician provides telehealth services from our facility to patients at home?**

   No. The telehealth blanket waiver enacted by CMS does not change or expand the billing options or rules for hospitals with regards to telehealth. The only code available for hospitals to report on a UB04 claim type for telehealth services remains HCPCs code Q3014, "Telehealth originating site facility fee". Please note, this code is still only separately reportable if the patient is physically present at your facility and is receiving telehealth services from a provider located at a distant site (not the same facility). However, the individual practitioners providing these telehealth services may be able to submit a professional claim for these services (see additional questions if you bill for services using a CMS 1500 claim form). ***(last updated 4/6/2020)***

   (Updated on 5/7/2020) The only code available for hospitals to report on a UB04 claim type for telehealth services remains HCPCS code Q3014, "Telehealth originating site facility fee". The Interim Final Rule (CMS-5531 IFC, released on April 30, 2020) does allow a patient's own home to be considered a temporary expansion site of a provider-based department. For an explanation of this concept/policy, please see our reference document "Summary of Changes Related to Hospital Billing for Outpatient Service Rendered to Patients in Their Homes as Detailed in the CMS COVID-19 Interim Final Rule, CMS-5531-IFC, Published on April 30, 2020".

Professional Service Providers – those who bill on a CMS 1500 (or its electronic equivalent)

1. **Can all professional services be rendered via telehealth?**

   No, but CMS expanded the services it has deemed eligible to be provided through telehealth. Approximately, 90 additional codes have been added on a temporary basis since the public health crisis has been declared to include:

- Emergency department visits (99281-99285);
- Initial and subsequent observation and observation discharge day management (99217-99220; 99224-99226; 99234-99236);
- Initial hospital care and hospital discharge day management (99221-99223; 99238-99239);
- Initial nursing facility visits, and nursing facility discharge day management (99304-99306; 99315-99316);
- Critical care services (99291-99292);
- Domiciliary, Rest Home, or Custodial Care services (99327-99328; 99334-99337);
- Home visits (99341-99350);
- Inpatient neonatal and pediatric critical care (99468-99473, 99475-99476);
- Initial and Continuing Intensive Care services (99477-99480);
- Care planning for patients with cognitive impairment (99483);
- Psychological and neuropsychological testing (96130-96133, 96136-96139);
- Therapy services, physical and occupational therapy (97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507); and
- Radiation Treatment Management Services (77427).

To review the complete list of CMS approved telehealth services (by CPT/HCPCs code) please see CMS' list of covered telehealth services. ***(last updated 4/6/2020)***

(Updated on 5/7/2020) CMS added additional codes to the list of covered telehealth services. CMS indicated they believe the vast majority of services that are appropriate to be rendered via telehealth are enumerated. However, they left it open that should they identify additional services that could appropriately be delivered via telehealth, that they may add them with an expedited process during the PHE that does not involve notice and comment rulemaking. The covered telehealth services list also notes which services are considered on a temporary basis during the PHE.

2. If the eligible provider types and covered services remain the same, what did the blanket waiver actually change with regards to telehealth?

The CMS telehealth blanket waiver expanded the coverage of telehealth services to all Medicare beneficiaries. Prior to enaction of the waiver, telehealth services were only covered for those beneficiaries who resided in certain rural areas as defined by CMS. With the enaction of the waiver, all Medicare beneficiaries, regardless of geographic location can now receive telehealth services. The waiver also removed the requirement that beneficiaries receive telehealth services while physically present at a CMS defined originating site – most importantly, this means Medicare beneficiaries can now receive telehealth services in their own homes. Prior to the waiver, telehealth services could also only be furnished to patients with whom the provider had an established relationship. HHS has advised that for the duration of the COVID-19 public health emergency they will not audit for presence of an established relationship between the provider and the Medicare beneficiary. Lastly, HHS says it will exercise discretion and not impose penalties for noncompliance with HIPAA requirements with regards to certain technologies used to provide telehealth services during the public health emergency. ***(last updated 4/6/2020)***

3. Are there restrictions on which provider types can submit professional claims for telehealth services?

Yes. CMS lists the approved provider types as (subject to individual state law): Physicians, Nurse Practitioners, Physician Assistants, Nurse Midwives, Clinical Nurse Specialists, Certified Registered Nurse Anesthetists, Clinical Psychologists, Clinical Social Workers, Registered Dietitians, nutrition professionals and moonlighting residents functioning outside of their teaching program. Residents functioning inside of their GME teaching program still need to abide by the supervision rules as they apply to the PHE. All practitioners must have an active NPI, be enrolled and bill on CMS 1500 claim forms. ***(last updated 4/6/2020)***

(Updated on 5/7/2020) In a document entitled "COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers" CMS expanded the flexibility regarding the type of practitioners who may provide telehealth services for Medicare. A blanket waiver, with a retroactive effective date of March 1, 2020 through the end of the PHE, allows all types of health care practitioners who bill for professional services to be eligible to furnish telehealth services. This permits professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including PTs, OTs, SLPs, and others, to receive payment for Medicare telehealth services.

4. What if we are only able to provide audio communication (with no video component), can we still charge the service as telehealth?

No. The waiver does not eliminate the requirement that telehealth services must comprise two-way, real-time interactive, audio and visual communication. However, there are additional non-face-to-face services that do not require a video component that can be submitted on professional claim types. ***(last updated 4/6/2020)***

(Updated on 5/7/2020) CMS is waiving the video technology requirement for certain telehealth services, such as telephone E/M services and behavioral health counseling and educational services. On the list of covered telehealth services, CMS designates which codes can be provided with audio only interaction.

5. **Can an eligible provider submit a professional claim for telehealth services rendered to a patient physically located in the same facility? (e.g. a physician providing audio and video communication from the Emergency Department to a patient in the ICU at the same hospital)**

   No. CMS states services should only be reported as telehealth services when the eligible professional providing the telehealth service is not at the same location as the beneficiary. ***(last updated 4/6/2020)***

6. **Are there any specific claim requirements when submitting professional claims for telehealth services?**

   Yes. Prior to declaration of the PHE, professional claims for telehealth services were required to be reported with the Place of Service (POS) code of 02. Claim reimbursement was at the facility rate and no modifier was required. Under the PHE, physicians and other practitioners are asked to report the POS code that would be reported if the services were furnished face-to-face that best describes the nature of the care they are providing. This will allow the claims processing system to make appropriate payment for services furnished via telehealth that, if not for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished face-to-face. For example, new and established patient visits provided in an office setting are reimbursed at the *non-facility* rate. During the PHE, providers reporting telehealth services with a place of service other than 02 should append modifier 95 to the service. ***(last updated 4/6/2020)***

   There are several modifiers associated with telehealth services to be considered. Telehealth modifiers include:

   Modifier 95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System

   Report 95 modifier for telehealth services that are used with POS other than 02 during the PHE.

   Modifier G0 (G-zero) -Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke.

   Report G0 for services associated with diagnosis and treatment of acute stroke.

   Modifier GQ - Via asynchronous telecommunication systems.

   Report GQ if you are an Alaskan or Hawaiian provider enrolled in a federal telemedicine demonstration project.

   Modifier GT - Via interactive audio and video telecommunication systems.

   Modifier GT is limited to institutional claims billing under the CAH Optional Payment Method II.

   CMS clarified in Special Edition MLN Matters SE20011 that condition code DR and modifier CR are not required for telehealth claims billed during the COVID-19 public health emergency.

   CMS is also asking that practitioners who plan on providing telehealth services from a location other than their practice address on file with CMS (e.g. if a Physician will be providing telehealth services from their own homes instead of their practice's office) update their practice location with their MAC through their individual MAC's hotline phone number. ***(last updated 4/6/2020)***

7. **Why aren't virtual check in codes (G2010; G2012) and e-visits (99421-99423; G2061-G2063) on Medicare's list of covered telehealth services?**

   CMS' terminology for this service avoids using the term "telehealth". Almost every state has enacted some form of reimbursement law or regulation for telemedicine, yet the laws and regulations vary significantly from one state to the next. The term telehealth has different meanings to different payers and patients. CMS believes

that the statute which applies limitations to Medicare telehealth services apply particularly to the kinds of professional services that are explicitly enumerated in the statutory provisions, like professional consultations, office visits, and office psychiatry services. Telehealth services are a specific set of services which are ordinarily furnished in-person but are instead furnished using interactive, real-time telecommunication technology. That is different from certain other kinds of services – like virtual check-ins and e-visits -- that are furnished remotely using communications technology. Virtual check-ins and e-visits are not considered "Medicare telehealth services" and are not subject to the restrictions articulated in section 1834(m) of the Act. ***(last updated 4/6/2020)***

8. Do patients have co-share responsibilities for the virtual check-in code G2012, telehealth visits, and e-visits?

Yes. However, CMS has indicated flexibility for healthcare providers to reduce or waive cost-sharing during the COVID-19 crisis. ***(last updated 4/6/2020)***

9. What does Medicare mean when they refer to telehealth visits?

Telehealth visits are visit services that are ordinarily furnished in-person but are instead furnished using interactive, real-time telecommunication technology. Examples include, but are not limited to, 99201-99215 (office or other outpatient visits); G0425-G0427 (telehealth consultations, emergency department or initial inpatient); and G0406-G0408 (follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs. CMS has the complete list of covered telehealth services for the PHE on their website. ***(last updated 4/6/2020)***

10. How do I indicate that my E/M was performed as a telehealth visit rather than in-person?

Services that are provided as telehealth are normally reported with Place of Service (POS) code 02 and then paid at the facility rate. Under the waiver during the PHE, the POS code should reflect the POS code that would have been reported had the service been furnished in person. On an interim basis, modifier 95 (Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System) should also be reported. When a telehealth service is not reported using POS 02, this will cause claims to be paid at the non-facility rate when the physician is in an office setting rather than the facility rate. ***(last updated 4/6/2020)***

11. During the COVID-19 crisis, how am I to level my telehealth E/M?

CMS is permitting telehealth visits (99201-99215) conducted during the PHE to be leveled based on either time or medical decision making. Consider this an early application of the guidelines that were already planned to begin in 2021. The current definition of medical decision making is being maintained. ***(last updated 4/6/2020)***

(Updated on 5/7/2020) In the Interim Final Rule (CMS-5531 IFC, released on April 30, 2020) CMS acknowledged their previous instruction on leveling E/Ms furnished via telehealth based on time or medical decision making may have been confusing because two different sets of time exist between the current CPT code descriptors and a CMS public use file made available on their website. Therefore, on an interim basis for the duration of the PHE, the times that are specified in the CPT codes descriptor should be used as the typical time for purposes of level selection.

12. Are phone call services eligible for payment by Medicare?

Prior to the public health emergency (PHE), CMS considered phone call services bundled, and therefore, not separately payable. However, during the PHE, CMS has indicated that phone call services may be eligible for payment. Available CPT codes include:

For physicians, NPs, PAs, and CNSs: 99441-99443

99441 - 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; 5-10 minutes of medical discussion

99442 - 11-20 minutes
99443 - 21-30 minutes

For other clinicians: 98966-98968

98966 - Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967 - 11-20 minutes
98968 - 21-30 minutes

Payment for these services will be based on already established RVUs. Codes 98966-98968 are considered "sometimes therapy" and would require the corresponding modifier GO, GP, or GN when performed by PT, OTs, and SLPs. ***(last updated 4/6/2020)***

13. Other than telehealth services and telephone services, what other type of non-face-to-face services will CMS cover?

Other virtual encounters covered by CMS include Virtual Check-Ins (G2012/G2010) as well as E-visits (CPTs 99421-99423, HCPCS G2061-G2063). It is important to remember these codes are also only billable on professional claims. These codes are not billable on a UB04 claim type and there are no associated technical charges for these services. ***(last updated 4/6/2020)***

14. Are virtual check-in services the result of the COVID-19 virus?

No. Recognizing and paying for virtual check-ins is an interesting development in health care access that started before COVID-19 was on the horizon. Unique codes (G2010 and G2012) were implemented in January 2019, well before COVID-19 was declared a pandemic by the WHO in March 2020. There has been a growing trend to reimburse provider work that is performed outside of traditional office visits. Virtual check-ins can be used to evaluate whether or not an office visit or other service is warranted and help avoid unnecessary trips to the doctor's office. It can cover a broad array of services, including monitoring patients starting a new medicine or those trying to manage chronic illnesses, such as diabetes. ***(last updated 4/6/2020)***

15. What is the virtual check-in code?

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

Virtual check-ins allow patients to connect with their doctor through a variety of communication methods that do not require physical presence. CMS feels this type of service will resolve patient concerns in a convenient manner that gets them the care they need and possibly avoid unnecessary costs to the system. This can help alleviate transportation concerns to and from provider offices which can be a big burden especially for elderly

and disabled populations and their caregivers. Check-ins are not intended to replace office visits but rather to augment them and provide new access points for patients. It is designed to accelerate the use of patient engagement and remote patient monitoring in the market. ***(last updated 4/6/2020)***

16. What is the difference between 99441 (phone call) and G2012 (virtual check-in)?

The CPT code 99441 is limited to and specific to phone calls. The HCPCS code G2012 includes phone calls, but is not limited to phone calls. It encompasses a broader array of communication modalities. ***(last updated 4/6/2020)***

17. Is G2012 only available for established patients?

It is expected that virtual check-in services are, for the most part, initiated by established patients. It is certainly possible though that patients may need to be advised of the availability of a virtual check-in and agree to it prior to receiving the service. Patient consent for the service should be documented in the medical record. During the COVID-19 crisis, CMS will allow virtual check-ins to be performed for both new and established patients. ***(last updated 4/6/2020)***

18. Who can render G2012?

Eligible provider types include physicians, nurse practitioners, and physician assistants. However, during the PHE, the Interim Final Rule is expanding eligible provider types to include PTs, OTs, and SLPs in private practice. These codes will be designated as "sometimes therapy" and will require the corresponding GO, GP, or GN modifier when reported by a therapist under a plan of care. ***(last updated 4/6/2020)***

19. What is code G2010 regarding the remote evaluation of pre-recorded patient information?

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 or procedure within the next 24 hours or soonest available appointment.

This code was also implemented in January 2019. It provides a way of reporting and being reimbursed for a provider's asynchronous review of recorded video and/or images captured by a patient in order to evaluate the patient's condition and determine whether or not an office visit is necessary. This type of review is referred to as "store-and-forward" communication technology. To bill for this service, there must be follow up with the patient after review of the recorded video and or images within 24 "business" hours. The follow-up could take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication. It does not need to be verbal. Any such communications must be compliant with HIPAA and other relevant laws. Please note there is some relaxation for certain technologies during the public health emergency. When the quality of the pre-recorded information submitted by a patient is insufficient for the clinician to assess whether an office visit or other medical service is warranted, the clinician could not fully furnish a remote evaluation service and, therefore, could not bill for the service. ***(last updated 4/6/2020)***

20. What is an "e-visit"?

Codes for e-visits were added to the CPT code set effective January 1, 2020. E-visits are digital services conducted using an online patient portal. ***(last updated 4/6/2020)***

21. What codes are applicable to e-visits?

99421-99423; 98970-98972; and G2061-G2063. Nine codes were created to describe e-visits. Code selection is dependent on the payer and the type of provider rendering the service. While it is not at all clear in the code

descriptors, 99421-99423 can be reported by practitioners who can independently bill E/M services, which includes not only physicians, but also nurse practitioners, clinical nurse specialists, and physician assistants. When the e-visit is rendered by a clinician who cannot independently report E/Ms, codes 98970-98972 should be considered (depending on the payer). It is important to note that Medicare will not recognize codes 98970-98972. Medicare created the G codes (G2061-G2063) to more clearly delineate that these are "assessment" services rather than "E/M" services. Clinician types that should consider 98970-98972 or G2061-G2063 include, but are not limited to, speech language pathologists, physical therapists, occupational therapists, social workers, psychologists, dietitians, etc.

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

98970 - 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; 5-10 minutes

98971 -11-20 minutes
98972 - 21 or more minutes

G2061 - Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes

G2062 - 11-20 minutes
G2063 - 21 or more minutes

(last updated 4/6/2020)

22. Are we still required during the PHE to get patient consent for non face-to-face services that will incur a patient co-share?

Yes. Patient consent is still required. Documentation of consent may be documented by auxiliary staff under general supervision. Consent is required at least annually. Consent may be obtained at the same time the service is furnished. ***(last updated 4/6/2020)***