2021 NCODA Fall Summit

The Evolution of Telehealth Services Within Oncology

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Telepharmacy & Pilot Program

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What is Telepharmacy?

- ASHP defines telepharmacy as a method used in pharmacy practice in which a pharmacist utilizes telecommunications technology to oversee aspects of pharmacy operations or provide patient care services."

Where do we start?

- Due to the COVID pandemic the virtual MD office visit experience increased. How do we as a pharmacy pivot and incorporate a virtual visit into our practice?

TXO Telepharmacy Pilot Project

- Initial engagement of with Leadership and Pharmacist to develop a collaborative support team
- Billing of Services or Extension of services
- Regulations (State and Federal)
- Implementation date
- Goal Setting

Initial Engagement

- How do we want to utilize telepharmacy within our organization?
- TXO decided to launch telepharmacy as an extension of pharmacy services.

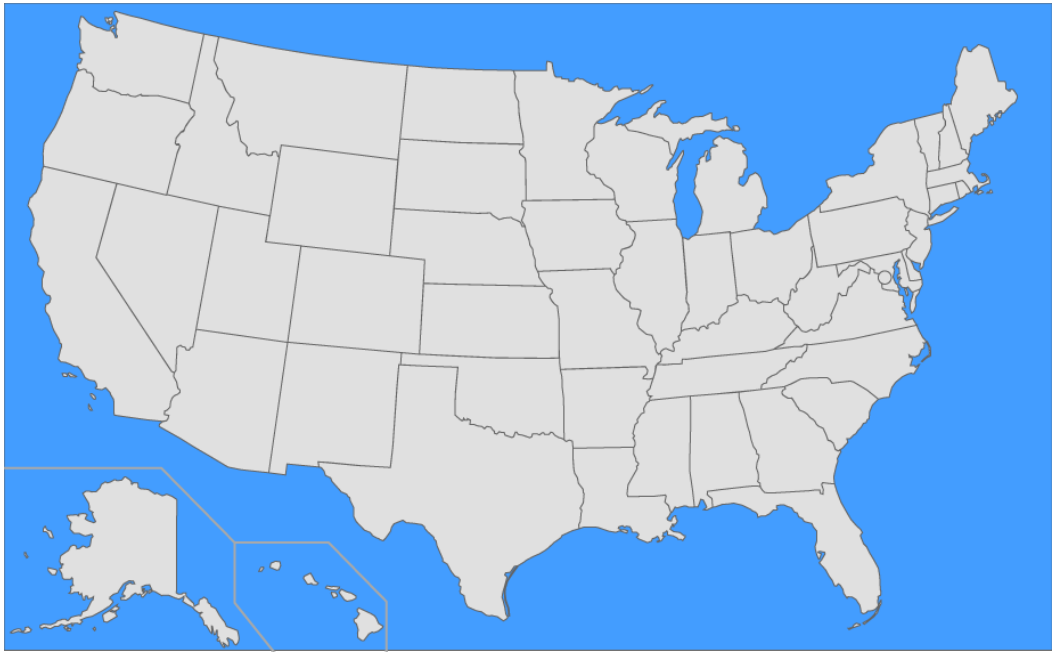
The Team

- Pharmacy Leadership
- Pharmacist
- Physician Champion
- Marketing, Public Relations
- Director of Virtual Care
- Information Technology
- Practice Management/ Revenue Cycle

Regulations

- Federal- CMS.gov

- State- check your local State Board of Pharmacy.



Implementation date

August 2021

Getting Ready- Things to think about…

- Environment
  - Pharmacy space
  - Remote office space
  - Background
  - Noise level- headphones (?)
  - Camera(?)
- Software
  - Vsee –internal software that is HIPPA compliant
  - Practice Management system-schedule appointments and send appointment reminders

Launch Telepharmacy Services

- Pharmacist- identify patient in advance
- In-service Pharmacist and Pharmacy Technicians
  - Detail making appointments
  - Using the Vsee app
  - Draft emails and text messages with Vsee instructions in English and Spanish, for both iphones and androids
- EMR documentation of visit

EMR Documentation

Medication Name: Calquence 100mg
sig: Take 1 capsule by mouth every 12 hours

Patient was Counseled on the following information:

- See chart…..

1. Adherence: no missed doses

- Directions verified: yes patient taking according to prescribers direction.
  Pills remaining: 22
  Next fill: 09/21/21

2. Patient identifies side effect(s): Patient stated that she has had trouble sleeping. We reviewed the drug monograph of calquence and did not see any reported side effects of insomnia. She denies any headache, diarrhea, abnormal bruising, and irregular heart rhythm. she does state she feels a little tired but it is a common occurrence for her.

3. Counseling on side effects acknowledged by patient: yes

4. Review of medication: Reviewed the patients medication history. No new medications, OTC or herbal supplements added. All vaccines are up to date.

5. Safe handling: no issues
6. Drug / food interactions: pt is avoiding heart burn medications and grapefruits.
7. Plan for missed doses: Not applicable

Next fill scheduled for:09/21/21

Review refill process/refill pharmacy contact information: pt acknowledged that she understood

Additional Notes:

XXXXXXXXXX PharmD

Can open prescription container	(Y/)
Can swallow medication	(Y/)
Indication	(Y/)
Schedule and Start Date	(Y/)
Side Effects	(Y/)
Food and Drug interactions	(Y/)
Safe Handling	(Y/)
Plan for Missed doses	(Y/)
Clinic Contact information provided	(Y/)
How to obtain refills	(Y/)

Evaluation of the Pilot

- How often? 30, 60, 90 days
- Persistency and Adherence
- Timeliness of refills
- Telepharmacy appts: completed vs. appts canceled
- Patient feedback of services

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CMS, Billing, & Coding

NCODA

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Disclaimer

The information described herein is subject to change as many of the details herein are subject to interpretation. Regulations are coming out everyday and many of them are VERY unclear.

All Medicare information is derived from published rules; however, interpretations may be erroneous and typos may be evidenced. It is mandatory that coding and billing is based on information derived from each practice or clinic.

This is not legal or payment advice.

This content is abbreviated for Medical Oncology. It does not substitute for a thorough review of code books, regulations, and Carrier guidance.

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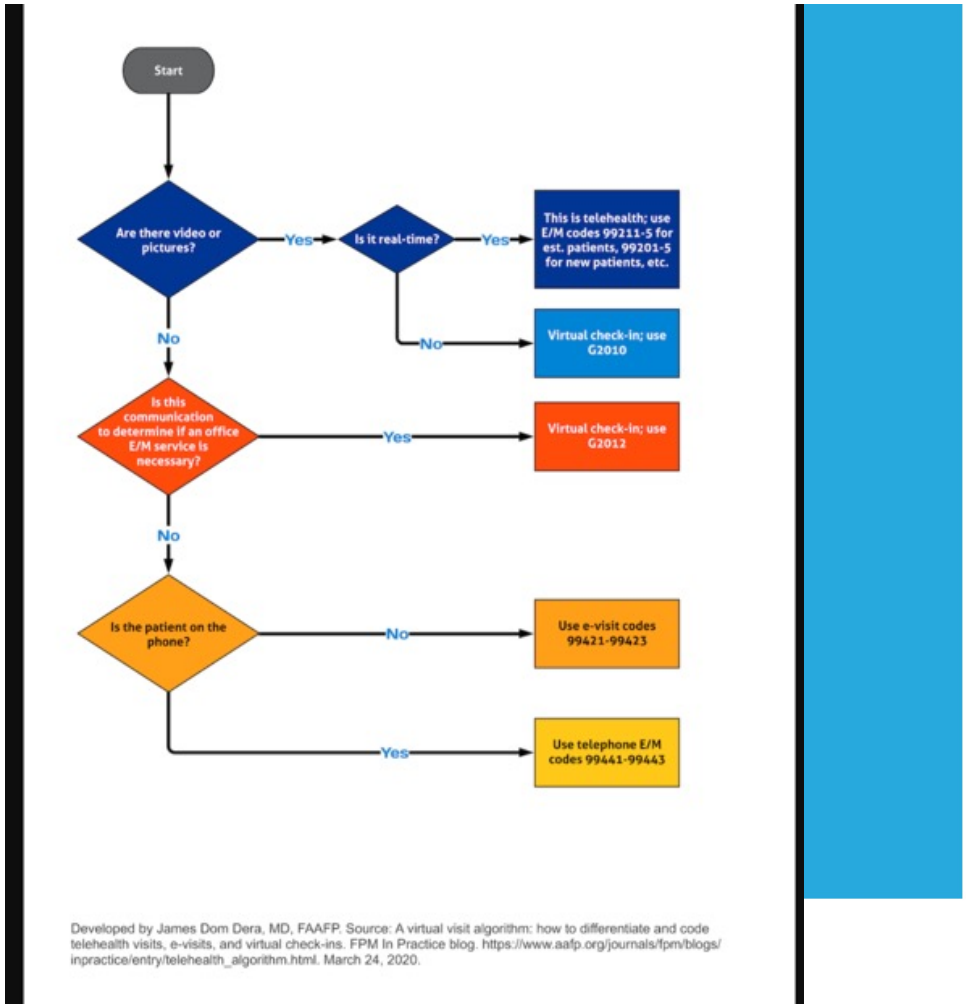
- Telemedicine: Use of electronic information and telecommunications technologies to support and promote long-distance clinical health care.
- Telehealth: Medicare-specific benefit to identify services provided via 2-way, real-time audiovisual technology to a Medicare beneficiary that meets the defined criteria.
- Virtual check-in: Medicare term for a brief check in with a provider via telephone or other telecommunications device to determine if a face-to-face visit is needed.
- E-visit: Brief communication between the patient and provider through an online patient portal or other approved HIPAA-compliant technology.
- Telephone Calls: Provider evaluates the patient through an audio phone.

- **Deciding What Service to Use**



Developed by James Dom Dera, MD, FAAFP. Source: A virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins. FPM In Practice blog. https://www.aafp.org/journals/fpm/blogs/inpractice/entry/telehealth_algorithm.html. March 24, 2020.

- Medicare Telehealth

Medicare's Non-PHE Telehealth Policy

A visit with a provider that uses real time, interactive audio-visual telecommunication systems between a provider and a patient.

Common telehealth services include:

99201-99215 (Office/other outpatient visits)

G0425-G0427 (Telehealth consultations, ED or initial inpatient)

G0406-G0408 (Follow up inpatient telehealth consultations in hospitals or SNFs)

Full list of covered services updated annually

https://www.cms.gov/Medicare/Medicare-General Information/Telehealth/Telehealth-Codes

CMS: Equipment Needed for Telehealth

- Question: Is any specialized equipment needed to furnish Medicare telehealth services?
- Answer: Currently, CMS allows telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication, they qualify as acceptable technology. For more information:
  - https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/index.html

On 3/30/2020

The list was greatly expanded as the requirement for the patient to be ESTABLISHED was waived so all kinds of new codes were added such as:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316) • Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473;CPT codes 99475- 99476)
- Initial and Continuing Intensive Care Services (CPT code 99477- 9947
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- **Radiation Treatment Management Services (CPT codes 77427)**
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

The full list of codes is at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telehealth and Chronic Care Management

- Tradition CCM and Principal Care Management are not virtual codes because they are virtual by the nature of their content
- But, some codes are on the telehealth list and can be done right now via telehealth are the following:
  - Advance Care Planning
  - Transitional Care Management

Additionally Some Things Were Changed

- The following services no longer have limitations on the number of times they can be provided by Medicare telehealth:
  - A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233)
  - A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
  - Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509)

Telehealth and COVID-19 (3/6/2020)

- Before COVID-19 "Traditional"
  - Patient must be in an underserved area
  - Patient must go to healthcare facility or provider
  - Requires two-way interactive audio-visual communication
  - Must use a HIPAA-compliant platform
  - May only use codes for CMS list
- After COVID-19
  - Patient can be anywhere
  - Patient can be at home or in a facility
  - Requires two-way interactive audio-visual communication
  - Need for a HIPAA compliant platform softened
  - May only use codes from CMS list, which expands constantly

HIPAA Platform Waiver

- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.
- OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
- A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients.

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Telehealth Versus Remote Services

- Telehealth is governed by statute and has certain requirements, which other virtual services are not.
  - Several conditions must be met for Medicare to make payments for telehealth services under the PFS. The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:
    - The service must be furnished via an interactive telecommunications system. This has been modified to include Facetime, SKYPE, etc. But NO telephone.
    - The service must be furnished by a physician or other authorized practitioner.
    - The service must be furnished to an eligible telehealth individual.

Eligible Providers for Telehealth

- DISTANT SITE PRACTITIONERS Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:
  - Physicians
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Nurse-midwives
  - Clinical nurse specialists (CNSs)
  - Certified registered nurse anesthetists
  - Clinical psychologists (CPs)
  - Clinical social workers (CSWs)
    - CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838
  - Registered Dietitians or nutrition professionals

New Patients Under COVID-19

- "It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. "

How To Code E/M in Telehealth

Clinicians can provide these services to new or established patients

You can do counseling and coordination of care. But, just like FTF visits, it must be documented correctly with three elements:

- Time of counseling
- Total time of visit
- Reason for counseling

All E/M for Office visits

- You can use time or medical decision-making as described in CPT 2021, for Office Visits 99201-99215
  - All time on the day of the encounter by the physician is what is billed, a glimpse into the future. But, time is the CMS time for Medicare patients.
  - History and physical for office visits is no longer necessary to code

Billing for Telehealth: Medicare 3/30/2020

- Submit claims for telehealth services using:
  - There are no specific diagnosis guidelines for Medicare
  - The appropriate CPT or HCPCS code for the professional service from the Medicare-approved list
  - Place of Service 11 if billing for waivered COVID-19 TELEHEALTH in your office with Modifier -95, which attests that you used interactive real time technology
  - Paid at the NON-FACILITY rate, if you use the POS 11
  - Again, if you bill using a POS other than 02, use Modifier -95 for Medicare, which means Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System…

Other Medicare Coding/Modifiers

- Place of Service (POS) 02: The location where health services and health related services are provided or received, through telehealth telecommunication technology. If billing for TRADITIONAL TELEHEALTH (Patient in a rural area, etc).
- Modifier –GT for Telehealth via interactive audio and video telecommunication systems. This was used by CMS prior to 2018 when 02 was adopted in its stead. Still used by private insurance.
- Modifier –GQ is used by Alaska and Hawaii for asynchronous technology. They have an exemption.
- Modifier -G0 is Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke. This is a modifier by Medicare for special stroke telehealth.

Supervision of "Incident To"

- For the reasons discussed above, on an interim basis for the duration of the PHE for the COVID-19 pandemic, we are altering the definition of direct supervision at § 410.32(b)(3)(ii), to state that necessary presence of the physician for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We are revising § 410.32(b)(3)(ii) to include, during a PHE, as defined in § 400.200 of this chapter, the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider."
- This may become permanent

Home Drug Infusion

- Question: For physicians that are providing needed drugs in the patient's home incident to their professional services using auxiliary personnel, are there changes to physician supervision requirements?
- Answer: Through this interim final rule, CMS is altering supervision requirements for physicians and other practitioners. For the duration of the PHE for the COVID-19 pandemic, CMS is altering the definition of direct supervision at § 410.32(b)(3)(ii), to provide that the necessary presence of the physician or other practitioner for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We also note that this new flexibility would apply where the physician practice contracts with an entity for auxiliary personnel as defined in our regulation at §410.26(a)(1), including a home health agency, or a qualified home infusion therapy supplier, to provide incident-to services in the patient's home.

Check-ins, E-visits: Virtual Services 2020

- Not Telehealth

Pre-COVID Telehealth Versus Remote Codes

- TRADITIONAL Telehealth
  - Ruled by statute definition for Medicare
  - List of many codes including E/M, but requirements the same
  - Two-way real time communication
  - Limited to HPSA patients in HC setting
  - Limited providers
  - Place of Service 02
  - Paid at FACILITY rate when there are 2 rates
- Remote Codes
  - Each code has unique requirements
  - Time-based codes for the most part
  - Variety of media--phone, patient portals
  - Many of these codes are patient-initiated, but CMS has lightened that
  - Paid at Non-Facility rate (shown in our slides)

Post-COVID Telehealth Versus Remote Codes

- COVID-19 Telehealth
  - Ruled by statute definition for Medicare
  - List of many codes including E/M, criteria altered
  - Two-way real time communication
  - Patient or provider can be anywhere
  - Limited providers
  - Place of Service what it would have been FTF
  - Paid at Non-Facility in POS 11
- Remote Codes
  - Each code has unique requirements
  - Time-based codes for the most part
  - Variety of media-phone, patient portals
  - Many of these codes are patient-initiated, but CMS has lightened that
  - Most require MD or NPP
  - Paid at Non-Facility rate (shown in our slides)

Brief Check-in: G2012

Topic	G2012
National NF Reimbursement 2021	$14.66
When Used	When there is no E/M 7 days before or 24 hours later (or soonest)
Encounter time frame	5-10 minutes
FTF or Virtual?	Virtual
Who Can Do	MD or NPP
Supervision	Incident to for NPP?
Consent	Verbal
OCM?	Yes

Technology for G2012

- Can be a variety of technology:
  - Patient portal
  - HIPAA-compliant video with audio
  - Or, the telephone, but must be one on one with the billing provider

Billing/Coding for G2012

- Starting January 1, 2019, a physician or QHCP may bill for a virtual check-in with HCPCS Code G2012. In doing so, it is important to keep the following parameters set forth in the rule in mind:
    1. Established Patients. The patient on the other end of the check-in must be an "established patient" of the billing physician/QHCP. The rule defines an established patient as one who has received professional services within the past three years from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice. Waived for COVID-19 3/30/2020
    2. Billing Practitioner. The new code explicitly requires direct interaction between the patient and the billing practitioner. It is NOT billable if the evaluation is performed by clinical staff or a practitioner not qualified to furnish E/M services. (Note: in contrast, CCM codes CAN be billed for check-ins provided by nurses and other clinical staff, and can be billed concurrently with G2012 if the patient qualifies for such codes.)
    3. Copayments. As with other Medicare Part B services, the patient is responsible for a copayment for each billed service. May be waived
    4. Consent and Documentation. Verbal consent by the patient for each virtual check-in must be documented in the medical record. There is, however, no service-specific documentation requirement.
    5. Timing of In-person Visit. If the virtual check in (i) takes place within seven (7) days after an in-person visit, or (ii) triggers an in-person office visit within twenty-four 24 hours (or the soonest available appointment), the service is NOT billable, and its payment is considered bundled into the relevant in-office E/M code.
    6. Frequency. There is no frequency limitation on the use of the code by the same practitioner with the same patient. However, the billing practitioner should be mindful that each service must be *medically reasonable and necessary* to qualify for payment by Medicare.

Patient Initiation of G2012

- Here's what CMS says about patient initiation:
  - "VIRTUAL CHECK-INS: In all areas (not just rural), ..Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation."

On-line Digital E/M Services 99421-99423

Topic	99421-99423
National Reimbursement NF 2021	$15.00-47.45
When Used	Cumulative time for a seven-day period
Encounter time frame	5-21+ minutes
FTF or Virtual?	Virtual through HIPAA compliant portal
Who Can Do	MD or NPP
Supervision	N/A
Consent	Verbal
OCM?	Yes

Billing and Coding 99421-99423

These codes are for use when E/M services are performed, of a type that would be done face-to-face, through a HIPAA compliant secure platform.

These are for patient-initiated communications and may be billed by clinicians who may independently bill an E/M service.

They may not be used for work done by clinical staff or for clinicians who do not have E/M services in their scope of practice.

Must be an ESTABLISHED patient
Waived for COVID-19

Billing and Coding 99421-99423

- Report these services once during a 7-day period, for the cumulative time. According to CPT 2020®,
  - "The seven-day period begins with the physician's or other qualified health care professional's (QHP) initial, personal review of the patient-generated inquiry. Physician's or other QHP's cumulative service time includes:
    - Review of the initial inquiry
    - Review of patient records or data pertinent to assessment of the patient's problem
    - Personal physician or other QHP interaction with clinical staff focused on the patient's problem, development of management plans, including physician or other QHP generation of prescriptions or ordering of tests
    - Subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent separately reported E/M service"

Billing and Coding 99421-99423

- Verbal consent is required by CMS
- The patient initiates the service with an inquiry through HIPAA compliant technology, such as an electronic health record portal, secure email or other digital applications
- The service is documented in the medical record
- Time-based codes: Time must be obvious in documentation. Staff time is not included here
- If the inquiry is about a new problem (from the problem addressed at the E/M service in the past 7 days), these codes may be billed
- If within seven days of the initiation of the online service a face-to-face E/M service occurs, then the time of the online service or decision-making complexity may be used to select the E/M service, but this service may not be billed
- This may not be billed by surgeons during the global period

98970-98972 Digital E/M by Qualified NPPs

Topic	98971-98973
National NF Reimbursement 2021	$11.86-32.80
When Used	Cumulative time within a 7-day period
Encounter time frame	5-21+ minutes
FTF or Virtual?	Virtual through HIPAA compliant portal
Who Can Do	NPP who cannot perform E/M
Supervision	N/A
Consent	Verbal
OCM?	Maybe

Billing for NPP E-visits 98971-98973

- Use 98970-98972 in 2021.
- Established patient criteria waived for COVID-19.
- Used for Qualified Health Professionals (“NPPs”) who do not do Evaluation and Management Services.
- The POS is the location of the billing practitioner. In the case with remote services, the locality that is assigned to the claim is based on the place where the claims service was rendered. Therefore, in this situation, if the advanced practitioner doing the monitoring is in, for example, Maryland, and the beneficiary is in New York, the locality or POS is Maryland.

Billing for NPP E-visits 98970-98972

- Initiated by an established/existing patient (waived), conducted through a patient portal.
- Medically necessary (requires *clinical decision-making* and is not for administrative or scheduling purposes).
- Documented and stored to reflect the clinical decision-making and amount of cumulative time spent providing e-visit services to each patient.
- Clinicians may report an e-visit code only once per seven consecutive days. Select the appropriate G-code based on the *cumulative time* spent providing e-visit services to each patient, through a patient portal, over the course of the seven days. Day one of the seven days begins on the first date you provide an e-visit. Telephone calls do not count towards the time for e-visits.

99441-99443: Telephone Calls

Topic	99441-99443
National NF Reimbursement 2021	$56.88-131.55
When Used	When there is no E/M 7 days before or 24 hours or soonest later
Encounter time frame	5-30 minutes
FTF or Virtual?	Virtual
Who Can Do	MD or NPP Who Can Bill E/M
Supervision	N/A
Consent	Patient must consent to cost
OCM?	Yes

CPT GUIDELINES FOR PHONE CALLS

AMA CPT® Guidelines

Section

Non-Face-to-Face Telephone Services

Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services. These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure. (Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem.)

(For telephone services provided by a qualified nonphysician who may not report evaluation and management services [eg, speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians), see 98966-98968)

98966-98968: Telephone Calls by NPPs

Topic	98966-98968
National NF Reimbursement 2021	$13.96-39.43
When Use	When there is no E/M 7 days before or 24 hours or soonest later
Encounter time frame	5-30 minutes
FTF or Virtual?	Virtual
Who Can Do	MD or NPP Who Cannot Bill E/M
Supervision	N/A
Consent	Patient must consent to cost
OCM?	Yes

Billing for Phone Calls (99441-99443)(98966-98968)

- The established patient criteria is waived for COVID-19
- These are to be used when technology is a factor
- Make sure to document
  - Attendees
  - The total time of the call
  - What was discussed

99446-99449: Interprofessional Consults

Topic	99446-99449
National NF Reimbursement 2021	$18.84-73.28
When Used	When there is no E/M 14 days before or 14 days later
Encounter time frame	5-30+ minutes
FTF or Virtual?	Virtual
Who Can Do	MD ONLY?
Supervision	N/A
Consent	Patient must consent to cost
OCM?	Yes

Coding and Billing 99446-99449

- Billing Practitioner. Billing for interprofessional services is limited to those practitioners that can independently bill Medicare for E/M services. Though the descriptors for codes 99446-99449 and 99451 only include "assessment and management service provided by a consultative physician," the text in the Rule includes consultative QHCPs, so long as the consulting QHCP is eligible to independently bill Medicare for E/M services. Other coding consultants disagree with this opinion. Check with licensure and your MAC.
- Consent. Verbal patient consent must be documented in the patient's medical record for each consultation. The patient's consent must include assurance that the patient is aware of applicable cost-sharing.
- Cost Sharing. Providers must collect the requisite copayment from the patient for each service billed. Lightened for COVID-19.
- Benefit of the Patient. The consultation must be undertaken for the benefit of the patient. Because the patient is going to be responsible for cost-sharing, CMS is concerned about distinguishing these Interprofessional Internet Consultations from those undertaken for the edification of the practitioner, such as information shared as a professional courtesy or as continuing education.

Coding and Billing 99446-99449

- May be a new or established patient to the consultant, for a new or existing problem; sometimes known as “Curbside Consults”
- Consultant may not have had a face-to-face service with the patient in the last 14 days
- May not bill if review leads to a face-to-face service with the patient in the next 14 days
- Majority of the time must be medical consultative verbal or internet discussion (greater than 50%)
- For 99446, 99447, 99448, 99449, if greater than 50% is in data review and/or analysis, do not bill those codes; according to CPT®, this doesn’t qualify

99451-99452: Interprofessional Consults

Topic	99451-99452
National NF Reimbursement 2021	$36.29-36.64
When Used	When there is no E/M 14 days before or 14 days later
Encounter time frame	5-30 minutes
FTF or Virtual?	Virtual
Who Can Do	MD ONLY
Supervision	N/A
Consent	Patient must consent to cost
OCM?	Yes

Caveats for Virtual Consults 99451-99452

99451	99452
• Codes 99446–99449 conclude with a **verbal opinion and written report by the consultant**; 99451 concludes with only a written report. • Communications of less than five minutes should not be reported. • The consultative codes should only be reported by the consultative physician; the treating/requesting physician can bill CPT code 99452 if the service takes 30 minutes or longer. • 99451 may be billed if more than 50% of the 5-minute time is data review and/or analysis	1. is reported by the physician/QHP who is treating the patient and requesting the non-face-to-face consult for medical advice or opinion — and not for a transfer of care or a face-to-face consult 2. is reported only when the patient is not on-site and with the consulting physician/QHP at the time of the consultation 3. cannot be reported more than once per 14 days per patient 4. includes time preparing for the referral and/or communicating with the consultant 5. requires a minimum of 16 minutes 6. can be reported with prolonged services, non-direct

General Rules for Virtual Consults

AMA CPT® Guidelines SHOW MORE

Section

Interprofessional Telephone/Internet/Electronic Health Record Consultations

The consultant should use codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/Internet/electronic health record consultations. An interprofessional telephone/Internet/electronic health record consultation is an assessment and management service in which a patient's treating (eg, attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.

The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (eg, a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.

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EXAMPLE OF PRIVATE PAYERS

- From Indiana

COVID-19 and Telehealth Coding Options as of 3/18/2020						
Payer	**Medicare Advantage**	**Commercial**	**Restrictions**	**Effective Dates**	**Billing Codes**	**What's Covered**
MODIFIERS AND PLACE OF SERVICE CODES						
GQ **GT** **95** **POS 2**	Services delivered via asynchronous telecommunications system Face-to-face encounter utilizing interactive audio-visual communication technology Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. Modifier 95 is only for codes that are listed in Appendix P of the CPT® manual. Telehealth services					
Aetna	See CMS guidelines **COVID-19 dx only**	Pays for two-way synchronous (i.e. real-time) **audio visual** interactive medical services between the patient and provider Any dx from 03/06/2020 to 06/04/2020	**Asynchronous** services are **not reimbursable** Self-insured plans may opt out	**03/06/2020 for 90 days (thru 6/4/2020)** Aetna's Telemedicine and Direct Patient Contact policy	Report codes from **Appendix P** in the CPT® book with modifiers **GT or 95**	No co-pay for telemedicine visits for any reason for 90 days and no cost share for all video visits through the Aetna-covered Teladoc offerings and in-network providers delivering synchronous virtual care (live video-conferencing) for all **Commercial** plans. Also covers **G2010, G2012, 99441, 99442, and 99443** during the 90-day period.
Anthem	See CMS guidelines	Pays for two-way synchronous (i.e. real-time) **audio visual** interactive medical services between the patient and provider Also applies to **Employer Group Retiree Medicare Advantage** programs	**Asynchronous** services are **not reimbursable** Services rendered by audio-only **telephone** communication, facsimile, e-mail, instant messaging, or other electronic communication are **not covered**.	Commercial Reimbursement Policy Subject: Telehealth Services Policy Number: C-08002 Effective: 7/19/2019	Telehealth specific CPT®/HCPCS code or telehealth modifier with codes from **Appendix P** in the CPT® book	Out-of-pocket expenses for the test used to diagnose COVID-19 will be waived for members who have fully insured, individual, Medicare and Medicaid plans. Providers should continue to verify eligibility and benefits for all members prior to rendering services. Members will pay any other out-of-pocket expenses their plan requires, unless otherwise determined by state law or regulation.
CMS/WPS Medicare	Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services to beneficiaries in any healthcare facility and in their home. Medicare coinsurance and deductible still apply for these services. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.			3/6/2020 and for the duration of the COVID-19 Public Health Emergency	POS 02 and GT modifier https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	"Virtual Check-Ins" w/ **G2012**, captured video or image w/ **G2010, G2061-G2063**, as applicable. Covers COVID testing and treatment with codes **U0001** and **U0002** Coinsurance and deductible waived. Medicare will process starting 4/1/2020 for dates of service on or after 2/4/2020.
Cigna		**Audio and video internet-based technologies** (synchronous communication), which would be reimbursed if the service was provided as a face-to-face office visit; Clinical condition is considered to be of **low to moderate** complexity, and while it may be an urgent encounter, it **should not be an emergent clinical condition**. Clinical condition requires **straight forward decision making**	Virtual care on the same day as a face to face visit, when performed by the same provider and for the same condition Service(s) performed via asynchronous communications systems (e.g., fax) Transmission of digitalized data Virtual care during the post-operative period of a major or minor surgical procedure	Reimbursement Policy Effective Date 06/15/2020 Reimbursement Policy Number R31 Virtual Care Updated is expected this week to expand telehealth services and may change the effective date	Place of Service (POS) 02 must be reported; Modifier 95 or GT is required and is appended to the appropriate CPT® and/or HCPCS procedure code(s)	96040, 96116, 96156, 96158, 96159, 96167, 96168, 97802, 97803, 97804, 99201-994203, 99211-99213, 99406-99409, G2070,G0296, G0396, G0397, G0438, G0439, G0442-G0447 Reimbursement for virtual care services will be made **50%** of the fee schedule or other allowed amount.
FSSA/IHCP Indiana Medicaid	**Videoconferencing** equipment that allows a medical provider to render an exam or other service to a patient at a distant location using the codes on the **Telemedicine Service Code list** http://provider.indianamedicaid.com/ihcp/Publications/providerCodes/Telemedicine_Services_Codes.pdf		Telemedicine services may be rendered in an inpatient, outpatient, or office setting. All services that are available for reimbursement when delivered as telemedicine are subject to the same limitations and restrictions as they would be if not delivered by telemedicine.	INDIANA HEALTH COVERAGE PROGRAMS PROVIDER REFERENCE MODULE Telemedicine and Telehealth Services, 10/1/2019	POS 02 and 95 modifier required GT modifier optional	No co-pays for COVID-19 diagnostic testing. Use U0001 and U0002, effective 4/1/2020, retroactively to claims for DOS on or after 2/4/2020

Payer	Medicare Advantage	Commercial	Restrictions	Effective Dates	Billing Codes	What's Covered
MODIFIERS AND PLACE OF SERVICE CODES						
GQ	Services delivered via asynchronous telecommunications system					
GT	Face-to-face encounter utilizing interactive audio-visual communication technology					
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. Modifier 95 is only for codes that are listed in Appendix P of the CPT® manual.					
POS 2	Telehealth services					
Humana	Effective 1/1/2020 Forprimary care, urgent care, mental health or substance abuse services, as defined by Humana; Provided by a physician or other qualified HCP **that has satisfied Humana's telehealth credentialing and recredentialing standards** and has a valid and effective contract with Humana; Provided through **real-time interactive audio or visual methods**. Must verify the member's identity before providing services and obtain verbal or written consent to receive the services, in accordance with state law. Humana commercial plans allow telehealth and interprofessional telephone or internet assessment and management services.		Internet-only telehealth services, CPT® codes 99421-99423, 99444 and 98969-98972, are not allowed unless provided pursuant to a Humana telehealth vendor partnership or when required by an applicable state mandate.	Humana Claims Payment Policy Subject: Telehealth Services Application: Medicare Advantage, Commercial and Medicaid Products Effective date: Commercial: 07/2008 Medicare Advantage: 02/2009 Policy number: CP2008102	Use modifier GT, modifier 95 and POS code 02 with appropriate CPT® and/or HCPCS procedure code(s)	Really hoping for more clarification on this one!
UHC	Any originating site requirements that may apply under Original Medicare or Commercial policies are waived so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. All CPT®/HCPCS codes payable as telehealth when billed with Place of Service 02 and the GQ or GT modifiers, as appropriate, under Medicare will be covered for Medicare Advantage plans for members at home during this time. Standard plan copays, coinsurance and deductibles will apply.			3/14/2020 thru 4/30/2020, may be extended UHC Provider Telehealth Policies March 14, 2020	(1) Codes recognized by CMS and appended with modifiers GT or GQ (2) Codes recognized by the AMA included in Appendix P of CPT® and appended with modifier 95 for Commercial plans	Our commercial and Medicare Advantage plans currently reimburse for "virtual check-in" patients to connect with their doctors remotely. These services are for established patients, not related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available). These services can be billed when furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010). UnitedHealthcare will also reimburse for patients to communicate with their doctors using online patient portals, using CPT® codes 99421-99423 and HCPCS codes G2061-G2063, as applicable.

What is Proposed for 2022

Status of the Public Health Emergency

- As expected, Xavier Becerra, the Secretary of the U.S. Department of Health and Human Services (HHS), has renewed the COVID-19 public health emergency (PHE), extending the many waivers that are in place until Jan. 16, 2022.

- This renewal was anticipated as the COVID-19 pandemic continues without an end in sight, with continued stress on healthcare workers, hospitals, nursing facilities, and other healthcare facilities around the country.

- Each declaration of a PHE by law lasts 90 days and must be renewed, with the previous extension issued on July 19, 2021.

- https://www.phe.gov/emergency/news/healthactions/phe/Pages/COVID-19.aspx

Understanding CMS

- Definitions of Telehealth Categories

- Category 1: *Services are similar to existing services, such as professional consultations, office visits, and office psychiatry services, which already are approved for telehealth delivery.* In deciding whether to approve the new codes, similarities between the requested and existing telehealth services are examined, including interactions among the beneficiary and the practitioner at the distant site and, if necessary, the tele-presenter, and similarities in the technologies used to deliver the proposed service.
- Category 2: *Services not similar to Medicare-approved telehealth services.* Reviews of these requests include an assessment of whether the service is accurately described by the corresponding CPT code when delivered via telehealth, and whether the use of technology to deliver the service produces a demonstrated clinical benefit to the patient.
- Category 3 — new in 2020: *Services that are likely to provide clinical benefit via telehealth; yet lack sufficient clinical evidence to evaluate making them permanent under Category 1 or Category 2.*These are to remain in effect until the end of the calendar year in which the COVID-19 public health crisis ends (not when the PHE ends).

Category 3 Proposal 2022

- **For the services that CMS does not permanently add to the Medicare telehealth list, CMS created a temporary Category 3. These services were added during the PHE, which will remain on the list through 2023**

- **CMS adds the following services to Medicare telehealth list on a Category 3 basis:**
  - **Domiciliary, Rest Home or Custodial Care services, Established Patients (CPT codes 99336-99337)**
  - **Home Visits, Established Patient (CPT codes 99349-99350)**
  - **Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)**
  - **Nursing facilities discharge day management (CPT codes 99315-99316)**
  - **Psychological and Neuropsychological Testing (CPT codes 96130- 96133)**
  - **Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)**
  - **Hospital discharge day management (CPT codes 99238-99239)**
  - **Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)**
  - **Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)**
  - **Critical Care Services (CPT codes 99291-99292) End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)**
  - **Subsequent Observation and Observation Discharge Day Management (CPT codes 99217; CPT codes 99224-99226)**

• Proposals for Telehealth 2022

- CMS also proposes to implement specific telehealth-related provisions of the CAA that addressed the provision of services for the diagnosis, evaluation or treatment of mental health disorders.
- Specifically, as directed by the Act, CMS proposes to require providers to conduct an in-person, non-telehealth service within six months prior to providing an initial telehealth mental health service, and at least once every six months following telehealth.
- All the rest of telehealth at home passed on waivers in 2020 will not remain after the PHE, unless Congress changes this.

What About Telephone ONLY Services?

- G2252 (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; 11-20 minutes of medical discussion.) Will remain a paid service in 2022.

- Other than that, the aforementioned mental health provisions apply to telephone calls also. For everyone else—buh-bye!
  - CMS proposes that a modifier is developed for these services.

Proposal for Supervision Via Telehealth 2022

- One waiver applies to “incident to.” CMS is seeking comment on whether this flexibility should potentially be made permanent, meaning that CMS will revise the definition of “direct supervision” to include immediate availability through the virtual presence of the supervising physician or practitioner using real-time, interactive audio/video communications technology without limitation after the PHE for COVID-19.

Bills in Congress: Latest

- Bill Number: HR 4040
- Bill Title: Advancing Telehealth Beyond COVID–19 Act of 2021
- Sponsor: Deborah Ann (Insley) Dingell
- Introduced Date: 06/22/2021
- Amends title XVIII of the Social Security Act to extend telehealth flexibilities under the Medicare program

Bills in Congress: Latest

- Bill Number: HR 3447
- Bill Title: Permanency for Audio-Only Telehealth Act
- Sponsor: Joshua S. Gottheimer
- Introduced Date: 05/20/2021
- Amends title XVIII of the Social Security Act to expand accessibility to certain telehealth services under the Medicare program.

To Do's Regarding Telehealth

- Keep an eye on the Public Health Emergency, but, for right now its is good news.
- Watch for the Medicare Final Rule to see what changes are permanent for 2022.
- To understand commercial insurance changes and your State laws, go to the Center for Connected Health Policy at https://www.cchpca.org/
- But, Remote Services are here to stay. Do not forget about them.

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