2019 Medicare Telehealth Coding Update

When Telehealth Coding Doesn't Use Telehealth Codes

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INTRODUCTION

Medicare is more conservative in its coverage of telehealth services compared to other insurers, due to its coverage being restricted by the Social Security Act. The Centers for Medicare and Medicaid Services (CMS) is considering the three new codes as physician services and paying for them on the physician fee schedule. The new Medicare approval for telemedicine consultation codes may prove to be of financial advantage to ophthalmic subspecialist consultants and non-specialists may benefit from the communication-technology based codes.

This article covers the new information and services that Medicare presented in the Final Rule for Physician Fee Schedule (PFS) under the heading "II D. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services…" The newly covered services are not designated as telehealth services, but rather *physician services,* based on their differences from those mandated in the telehealth restrictions in the Social Security Act. The article applies to Medicare Fee-For-Service reimbursement only.

For other payers, coverage is individualized for each state and insurer (including Medicaid) —so when you have seen one you have only seen one.

My main source of information for this article is the Department of Health and Human Services/CMS Final Rule for the Physician Fee Schedule that may be accessed here: https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions. It is also recommended that the following article from 2018 found on my website – www.RivaLeeAsbell.com - be reviewed as a foundation for this update: "**TELEHEALTH CODING —Medicare Regulations for Ophthalmology".**

HOW MEDICARE COVERS TELEHEALTH SERVICES

Medicare generally uses the term "Medicare telehealth services" to refer to the subset of services in the Social Security Act (The Act) that defines Medicare telehealth services and specifies the payment amounts and circumstances under which Medicare provides coverage and makes payment for a discrete set of services, ordinarily be furnished in-person (a face-to-face encounter), when they are instead furnished using interactive, real-time telecommunication technology.

The Act enumerates certain Medicare telehealth services and allows the Secretary to specify additional Medicare telehealth services using an annual process to add or delete services from the Medicare telehealth list. The Act also limits the scope of Medicare telehealth services for which payment may be made to those furnished to a beneficiary who is located in certain types of originating sites in certain, mostly rural, areas. Furthermore the Act permits only physicians and certain other types of practitioners to furnish and be paid for Medicare telehealth services. Although the Act grants the Secretary the authority to add services to, and delete services from, the list of telehealth services based on the established annual process, it does not provide any authority to change the limitations relating to geography, patient setting, or type of furnishing practitioner. However, the Bipartisan Budget Act of 2018 modified or removed the limitations relating to geography and patient settings for certain telehealth services, leading CMS to cover additional physician services by regarding services that ordinarily involve, and are defined, coded and paid for as if they were furnished during an in-person encounter between a patient and healthcare professional.

Three separate codes for services technically considered Physician Services rather than Telehealth services were added to Medicare coverage effective January 1, 2019 and are found in Current Procedural Terminology (CPT) under "Non-Face-To-Face Services:

- Virtual Check-in (I like to call it Checkup)
- Remote Evaluation of Pre-Recorded Patient Information
- Interprofessional Internet Consultations.

BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE, e.g. VIRTUAL CHECK-IN (HCPCS CODE G2012) ***Table I***

The term, Virtual Check-in, is used by CMS to describe a virtual encounter the patient has with the physician or other qualified nonphysician health care personnel, designated as Non Physician Practitioners (NPPs – eg, PA, Nurse Practitioner) who are **licensed** medical personnel with an **NPI number** who are permitted to directly bill Medicare for their services. This would **not** include ophthalmic technicians or technologists. Essentially, it is a virtual checkup. The characteristics are enumerated in Table I.

REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION (HCPCS CODE G2010) ***Table II***

In 2019 CMS issued notice in the final rule (noted previously) that Medicare would pay for services involving use of recorded video and/or images captured by a patient in order to evaluate a patient's condition. These services involve "store-and-forward" communication technology that provides for asynchronous (not in real-

time) transmission of health care information. The characteristics are enumerated in Table II.

INTERPROFESSIONAL INTERNET CONSULTATION (CPT CODES 99451, 99452, 99446, 99447, 99448 AND 99449) ***Table III***

The six CPT codes listed above describe assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician or other qualified healthcare professional ***requests*** *the opinion and/or treatment advice of a consulting physician or qualified healthcare professional* **with specific specialty expertise** to assist with the diagnosis and/or management of the patient's problem **without the need for the patient's face-to-face contact with the consulting physician** or qualified healthcare professional. Please keep in mind that Medicare is usually referring to fellowship trained specialists when using the term "Specialty" or "Subspecialty".

These services are not considered telehealth services since the patient is not required to be present. So, an encounter between two comprehensive ophthalmologists, one asking the other to come into the room with the patient and take a look at something and give an opinion does not qualify…it is not an internet communication and no specialty/subspecialty may be involved. The codes can also be found in the E/M section of the CPT book. However, the narrative information may not comply with all of Medicare's guidelines. This is the first use of consultation codes covered by Medicare since 2010.

CONCLUSION

This is an area that most practices and billers are not familiar with, but for those physician specialists who are being frequently consulted by their colleagues for assistance and opinions for managing complicated or unusual patients the new consultation codes are a way to be reimbursed for your expertise and the synchronous and asynchronous services provide an extra service that is now covered.

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Table I BRIEF COMMUNICATION TECHNOLOGY-BASED SERVICE – VIRTUAL CHECK-IN (HCPCS CODE G2012)	
Code Descriptor	▪ HCPCS 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).
Allowed Services Description	▪ CMS allows real-time audio-only telephone interaction in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.
Medical Necessity	▪ Throughout the document it is iterated and re-iterated "each of these services must be medically reasonable and necessary to be paid by Medicare." On my website (address noted above) there is a three-part series on Medical Necessity under Audits and Compliance entitled "Medical Necessity Can You Define That Please". This is the foundation for coverage of services for the Medicare program. Medical necessity is the determinant of whether or not any service is eligible for coverage and payment.
CMS Categorization	▪ CMS does **not** consider this service to be a telehealth service and will therefore issue payment under the physician fee schedule (PFS). Codes are **not** subject to Medicare geographic indexes and other telehealth restrictions.
Chart Documentation	▪ Each encounter must have an informed consent and the clinical findings are to be documented in the patient's chart as you would with a face-to-face encounter. The final rule states that no service-specific chart documentation requirements are listed; however, do not be lulled into complacency. The practitioner should document the same way as is mandated for a face-to-face encounter. Follow-up with the patient is mandatory and documentation of such must be entered into the chart.

Billing Time Limitations	▪ The virtual check-in encounter **cannot** be billed within 7 days after an in-person office visit nor can it be billed within 24 hours after a face-to-face encounter. The check-in encounter is considered bundled in the above two instances with the office visit encounters. This is a stand-alone service that can be billed as long as the above parameters are followed.
Patient Cost Sharing	▪ Patients are responsible for cost sharing for this service (co-payments).
New versus Established Patients	▪ This service may be rendered *only to established patients* since the practitioner needs to have an existing relationship with the patient and a basic knowledge of the patient's medical condition and needs in order to perform this service. CMS is using the CPT definition of an established patient, namely, one who has received professional services from the physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice.
Informed Consent for the Service	▪ Verbal consent for the service must be documented in the chart notes made for the encounter and CMS notes such consent must be entered into the medical record for each encounter.
Practice Utilization	▪ Utilization of the code G2012 will be monitored by CMS. CMS has not established specific frequency utilization limits.
Privacy	▪ Practices need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule.
Pricing	▪ Pricing was set based on a rate lower than the current E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communicative technology. National Average Payment for Non-Facility practitioners is $14.78 and for Facility practitioners is $13.33.

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Table II **REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATION (HCPCS CODE G2010)**	
Code Descriptor	▪ HCPCS CODE 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).
Allowed Services Description	▪ The scope of this service is limited to the evaluation of pre-recorded video and/or images. The follow-up with the patient can take place via telephone call, audio/video communication, secure text messaging, email, or patient portal
Medical Necessity	▪ Throughout the document is iteration and reiteration of "each of these services must be medically reasonable and necessary to be paid by Medicare." On my website noted above there is a three-part series on Medical Necessity under Audits and Compliance entitled "Medical Necessity Can You Define That Please?" This is the foundation for coverage of services for the Medicare program. Medical necessity is the determinant of whether or not any service is eligible for coverage and payment..
CMS Categorization	▪ CMS does not consider this service to be a telehealth service and will therefore issue payment under the physician fee schedule (PFS). The code is **not** subject to Medicare telehealth restrictions nor Medicare geographic indexes and other telehealth restrictions.
Chart Documentation	▪ Each encounter must have a written or verbal informed consent and the clinical findings should be documented in the patient's chart as you would in a face-to-face encounter, including the reason for the request.
Billing Time Limitations	▪ CPT code G2010 cannot be billed within 7 days after an in-person office visit. This is a stand-alone service that can be billed as long as the above parameters are followed. This service *is distinct from* the virtual check-in service described previously in that this service involves the practitioner's evaluation of a patient-generated still or video image transmitted by the patient, and the

	subsequent communication of the practitioner's response to the patient; while the virtual check-in service describes a service that occurs in real time and does not involve the asynchronous transmission of any recorded image.
Patient Cost Sharing	▪ Patients are responsible for cost sharing for this service (co-payments).
New versus Established Patients	▪ This service may be rendered *only to established patients* since the practitioner needs to have an existing relationship with the patient and a basic knowledge of the patient's medical condition and needs in order to perform this service. CMS is using the Current Procedural Terminology (CPT) definition of an established patient, namely, one who has received professional services from the physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice.
Informed Consent for the Service	▪ Verbal or written consent for the service must be documented in the chart notes made for the encounter and CMS notes such consent must be electronically entered into the medical record for each encounter.
Practice Utilization	▪ Utilization of the code G2010 will be monitored by CMS. CMS has not established specific frequency utilization limits.
Privacy	▪ Practices need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule.
Pricing	▪ If the virtual interaction results in an office visit, then the virtual visit will be bundled into the office visit. Pricing was set based on a rate lower than the current E/M in-person visits to reflect the low work time and intensity and to account for the resource costs and efficiencies associated with the use of communicative technology. National Average Payment for Non-Facility practitioners is $12.61 and for Facility practitioners is $9.37.

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Table III **INTERPROFESSIONAL INTERNET CONSULTATION** **(CPT CODES 99451, 99452, 99446, 99447, 99448 AND 99449)**	
Code Descriptors	▪ **CPT code 99446**: *Interprofessional telephone/Internet/ electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional;* ***5-10 minutes*** *of medical consultative discussion and review* **99447**: … ***11-20 minutes*** *of medical consultative discussion and review* **99448**: … ***21-30 minutes*** *of medical consultative discussion and review* **99449**: … ***31 minutes or more*** *of medical consultative discussion and review* Note that it is mandated that the majority of the service time (greater than 50%) must be devoted to medical consultative verbal or internet discussion. If greater than 50% of the time for the service is devoted to data review and/or analysis, the codes should not be reported. **CPT code 99451** *Interprofessional telephone/Internet/ electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time* **CPT code 99452** *Interprofessional telephone/Internet/ electronic health record referral services provided by a treating/requesting physician or other health care professional, 30 minutes of medical consultative time*
Code Clarifications	**RLA Discussion**: One of the most frequent questions is: what are the differences between 9944X codes and 9945X codes? Here is my analysis: ▶ CPT code 99451 requires only a written report whereas the 9944X codes require both a written and verbal report. ▶ CPT code 99451 is for the consulting physician whereas code 99542 is for the referring physician. ▶ CPT codes 99446-99449 + 99451 (the consultation itself) may only be performed by a physician whereas code 99452 is the **request** for a consultation and may be performed by a

	physician or other qualified health care personnel who are *licensed* in their specialty (eg, , Nurse Practitioner, Physician Assistant) who are listed by Medicare as eligible to obtain a *NPI number* and are *eligible to bill Medicare*. This excludes all categories of ophthalmic assistants, ophthalmic technicians, ophthalmic technologists and certified orthoptists.
New versus Established Patients	▪ This service may be rendered to *either new or established patients.* CMS uses a different definition for new patients, one that differs from that of CPT. For my article on Medicare's rules for coding new patients see: https://www.retinalphysician.com/issues/2014/jan-feb/coding-q-a
CMS Categorization	▪ CMS does *not* consider this service to be a telehealth service and therefore payment is issued under the physician fee schedule (PFS).
Billing Time Limitations	▪ The consultant should *not* have examined the patient in a face-to-face encounter within the past 14 days. If the consultation results in a transfer of care wherein the patient is examined within the next 14 days or when the next available date for appointment is made, then the consultation is considered bundled into that service. If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request, none of the codes should not be reported more than once within a seven-day period.
Informed Consent for the Service	▪ Verbal consent for the service must be documented in the chart notes made for the encounter. The patient's advance beneficiary consent is recommended and must include assurance that the patient is aware of applicable cost sharing (co-payments).
Practice Utilization	▪ Utilization of the codes will be monitored by CMS. Specific frequency utilization limits have not been established.
Privacy	▪ Practices need to comply with any applicable privacy and security laws, including the HIPAA Privacy Rule.
Pricing	▪ The following are Medicare's national averages for 2019. **99446 = $18.30** **99447 = $36.40** **99448 = $54.77** **99449 = $147.06** **99451 = $37.47** **99452 = $37.47**

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