Coding telehealth services during COVID-19

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The past year has been a time of transition in practice with a pivot in billable healthcare services. Telehealth is not a novel idea, but until the coronavirus disease 2019 (COVID-19) pandemic, it was not broadly used. The principal barriers to using telehealth services prior to the pandemic were reimbursement and parity laws.[1,2] The initial concept of telehealth use was a way to bring healthcare to rural and underserved populations. Telehealth services expanded during the pandemic as a means to continue patient care while mitigating the spread of COVID-19. Traditionally, most healthcare providers deliver face-to-face patient care, captured through Current Procedural Terminology (CPT) and evaluation and management (E/M) codes. Prior to COVID-19, many healthcare facilities did not have well-developed telehealth services because of reimbursement limits and/or a poor understanding of the regulations associated with telehealth services.

The CARES Act allows reimbursement of certain services provided with audio-only equipment.

Reimbursement and policy changes

In early 2020, the COVID-19 Public Health Emergency declaration was instituted, and regulatory waivers for billable healthcare services and expansion of telehealth and other technology-based communication services were introduced in March 2020, removing barriers and increasing accessibility to healthcare for Medicare beneficiaries in the US. Some states also enacted temporary policy changes regarding coverage of telehealth services for Medicaid beneficiaries.[3,4] Under the 1135 waiver and the Coronavirus Preparedness and Response Supplemental Appropriations Act, the Centers for Medicare and Medicaid Services (CMS) temporarily expanded Medicare telehealth benefits to all Medicare beneficiaries.[5,6] Previously, telehealth was only reimbursed by CMS for those in certain rural areas and required that the beneficiary travel to an originating site, such as a healthcare facility, to receive the service from the distant provider.[7]

The temporary waiver of certain telehealth reimbursement requirements allows for wider use of telehealth services involving a two-way, real-time interactive audio-video telecommunications system between patient and provider.[6,7] These services are billable for new or established patients with the ability to waive the Medicare copayments for these services.

Additionally, CMS waived the requirements of section 1834(m)(1) of the Social Security Act and 42 CFR 410.78(a)(3) under the Coronavirus Aid, Relief, and Economic Security (CARES) Act for video technology for certain services, allowing for reimbursement of services provided with audio-only equipment described by telephone E/M codes and some behavioral health counseling and educational services.[6] CMS has also waived the requirements of section 1834(m)(4)(E) and 42 CFR 410.78(b)(2), specifying which providers can bill for telehealth services.[6] In states where NP services require direct supervision via a physician or other practitioner, that supervision can be provided virtually using real-time audio/video technology.[6]

The traditional face-to-face healthcare services require documentation of key elements of a patient's history, physical exam, and provider's medical decision-making.[8] A concern with telehealth services prior to the pandemic was how to document these key elements without being face-to-face to conduct a thorough exam. For the duration of the public health emergency declaration, CMS is allowing level of service requirements to be based on time-based billing or on medical decision-making.

Coding and billing of telehealth services

The E/M services allowed to be provided by telephone only should be coded using CPT codes 99441-99443. These codes are equivalent to the Medicare payment for services that would otherwise be reported as an in-person outpatient office visit with established patients using audio-only technology. The Healthcare Common Procedure Coding System (HCPCS) code G2010 should be used when providing remote evaluation of a patient video or image and code G2012 should be used for remote synchronous evaluation of new and established patients using communication technologies such as the telephone for virtual check-in services.[6]

Remote patient monitoring services provided to monitor both new and established patients for acute and chronic health conditions should be billed using the appropriate CPT codes.[6] Current recommendations include using the following CPT codes:

99091: collection and interpretation of physiologic data
99457-99458: remote physiologic monitoring treatment management
99473-99474: BP self-measurement
99493-99494: psychiatric collaborative care

For example, if the NP is only remotely collecting and monitoring a patient's SpO_2 level using pulse oximetry, then the NP bills CPT code 99091; it is still imperative to document the necessary information in the patient's chart, including date, time, results, interpretation of results, and any follow-up with the patient regarding the data.

CMS has removed some previous limitations set on the number of times certain services can be provided through telehealth. For purposes of treating suspected COVID-19 infections, CMS currently allows remote physiologic monitoring services described by CPT code 99454 (device[s] supply with daily recording[s] or programmed alert[s] transmission each 30 day[s]) to be reported for shorter periods of time than the previous limitation set at 30 days.[6] Other modified services include the ability to perform a subsequent inpatient visit via telehealth, without the once-every-3-days limitation (CPT codes 99231-99233).[6] Likewise, a subsequent skilled nursing facility visit can be furnished via telehealth, without the once-every-30-days limitation (CPT codes 99307-99310).

CMS has also waived the requirement in 42 CFR 483.30 to perform in-person visits for nursing home residents. Therefore, NPs are now allowed to conduct these visits through telehealth options. There is also the option to use telehealth services to perform the required clinical exam of the vascular access sites for patients with end-stage renal disease.[6]

Current CMS recommendations favor use of the standard office-based E/M codes for remote telemedicine encounters performed in the outpatient setting. CMS recommends a point of service (POS) code of 11 during the COVID-19 public health emergency for telemedicine encounters to indicate that the patient would have normally been seen in an outpatient office setting. While the CPT codes used for reimbursement are the same as the in-person visit codes, the addition of telehealth modifier 95 needs to be included. The modifier 95 describes services furnished via telehealth and should be appended for such services delivered during the COVID-19 pandemic. It is important to comply with the regulations of each payor, since some payors, other than CMS, prefer a POS code of 02 to indicate telehealth services.[9]

> ***COVID-19 brought to light the need for a strategic action plan that aims to improve healthcare delivery methods across continuums.***

Conclusion

At the time of publication, it is unknown whether the emergency declaration, currently set to expire in late January 2021, will be renewed, with the future of telehealth to be determined. COVID-19 has certainly brought to light the need for a strategic action plan that aims to improve healthcare delivery methods across continuums. As we move beyond COVID-19, NPs must become familiar with technology-based healthcare platforms and appropriate billing codes used for reimbursement. NPs

must be ready to move forward with innovative leadership to create a more permanent resolution.

The guidance presented in this article is based on the information available at the time it was prepared, which was during the evolving COVID-19 pandemic. Therefore, there may be new developments that are not reflected within this article. Before using the information or codes listed within this article, review and verify the correct usage with the appropriate team of experts. The final decision for coding and billing of any service must be made by the healthcare provider in consideration with the insurance carrier's regulations and the local, state, or federal laws that apply to the provider's practice.

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