LIGHTHOUSE
HEALTHCARE ADVISORS LLC

Telehealth FAQ

1. **When do the new rules introduced by CMS 1135 Waiver apply?**

   The new CMS rules introduced March 17, 2020 retroactively apply to services provided on or after March 6, 2020.

2. **Will payers be reimbursing providers for waived cost sharing (i.e. copays, coinsurance, etc.) or will providers have to adjust off the waived cost sharing?**

   Aetna and Cigna will pay for the waived cost sharing for Covid-19 related services. United Healthcare and CareFirst BCBS of Maryland cost sharing will be adjusted off the claim for Covid-19 related services. For non-Covid-19 related services, cost sharing still applies for each of the commercial payers.

3. **Will cost sharing be waived for Covid-19 related services for out of network patients? Will reimbursement be impacted for Covid-19 related services for out of network patients?**

   CareFirst BCBS of Maryland will be waiving cost sharing for Covid-19 related services for out of network patients. For Aetna, Cigna, and United Healthcare the cost sharing for Covid-19 related services for out of network patients depends on the patient's plan. Reimbursement for out of network services will remain the same for each of the four commercial payers as it was prior to the Covid-19 pandemic.

4. **How are E&M codes that require a physical exam performed via telehealth?**

   On an interim basis, CMS has revised their policy to specify that the **office/outpatient E&M** level selection for these services when furnished via telehealth can be based on medical decision making (MDM) or time. These changes are similar to the policies finalized in the CY 2020 PFS Final Rule. Time is defined as all the time associated with the E&M visit on the day of the encounter (both face-to-face and non-face-to-face). CMS has maintained the current definition of MDM. The policy removes requirements regarding documentation of history and the physical exam in the medical record. CMS expect the practitioners to continue to document necessary information during visits to ensure quality and continuity of care. Below we have provided a grid outlining the general times the office/outpatient E&M visits (Source: CY 2020 PFS Final Rule). Please note these policies only apply to office/outpatient E&M visits furnished via telehealth during the PHE Covid-19 pandemic.

Code	Time (min)	Code	Time (min)
99211	< 10	99201	10
99212	10	99202	20
99213	15	99203	30
99214	25	99204	45
99215	40	99205	60

Commercial payers have remained silent on this matter and we recommend the following:

- Established patients only require 2 of the 3 elements for E&M codes (HPI, Exam, MDM) in order to bill for the service. Therefore, established E&M codes can be leveled based on HPI and MDM.
- New patients require all 3 elements. Providers have the option of performing an exam based on observation or billing based on time. Exams based on observation allow providers to assess skin tone, rate of breathing, gait, etc.Generally if you are unable to perform an exam with 100% certainty, you should recognize this as a limitation and document as such. You can document that, based on your exam, the patient appears to have (xyz) findings but this is a limited evaluation by telemedicine. A telemedicine exam is primarily focused on the history and what you can observe via video screen.
    - If documenting based on time, they must record the total length of time for the encounter. Recommended language: "I spent __ minutes with the patient, more than 50% of the time was spent in counseling and coordination of care as noted above."

5. Can providers bill for telephone calls without video capabilities?

Yes, you can report the following codes for provider telephone calls:

Physician Telephone Calls:

- 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 of medical discussion
- 99443 … 21-30 minutes of medical discussion

Qualified Non-physician Telephone Calls:

- 98966 Telephone assessment and management service provided by a qualified non-physician 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 of medical discussion
- 98968 … 21-30 minutes of discussion

CareFirst BCBS of Maryland is only considering code 99441 for reimbursement of physician telephone encounters regardless of time. Aetna, Cigna, and United Healthcare are all following CMS guidelines and reimbursing for each of the codes listed above for telephone encounters.

6. How is physical therapy being treated remotely for telehealth?

On March 31, 2020, CMS added therapy codes to the list of services approved for telehealth services. However, CMS has not authorized physical therapists as a provider type that can furnish telehealth as a covered service to Medicare beneficiaries under this legislation. The American Physical Therapy Association advises therapists to assume that they are not recognized as telehealth providers by CMS, and the association calls on member to urge CMS to expand telehealth waivers. Under Medicare Waiver 1135 physical therapists (in addition to occupational therapists, speech language pathologists, and clinical psychologists) can bill for e-visits. In its 2020 physician fee schedule final rule, CMS describes e-visits as "non-face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office." The code descriptors for the HCPCS codes related to e-visits suggest that the codes are intended to cover short-term (up to seven days) assessments and management activities that are conducted online or via some other digital platform and include any associated clinical decision-making. Under CMS guidelines an online patient portal is required to complete an e-visit and the patient must be an established patient. Physical therapists are eligible to use these HCPCS codes:

- G2061: Qualified non-physician health care professional online assessment and management, for an established patient, for up to seven days; cumulative time during the seven days, 5-10 minutes.
- G2062: Qualified non-physician health care professional online assessment and management service, for an established patient, for up to seven days; cumulative time during the 7 days, 11-20 minutes.
- G2063: Qualified non-physician qualified health care professional assessment and management service, for an established patient, for up to seven days; cumulative time during the 7 days, 21 or more minutes. (March 18)

Place of Service Code: Location where PT is providing the e-visit (i.e. 11 - Office)

Modifier: CR (catastrophic/disaster related)

CareFirst BCBS of Maryland is following CMS Waiver 1135 and allowing physical therapists to bill for e-visits. Aetna, Cigna, and United Healthcare have made their own policies in response to the Covid-19 pandemic and are allowing physical therapists to provide services

via telehealth. Please refer to our *LHA Telehealth Guide Addendum C* for more information on their policies.

99441-99443 are E/M codes for telephone services that cannot be billed by physical therapists. The non-physician codes for telephonic assessments are 98966-98968. Medicare has not provided any guidance on the use of these codes by physical therapists at this time.

For more information on physical therapy and telehealth please refer to these sources from the American Physical Therapy Association:
https://www.apta.org/PTinMotion/News/2020/3/16/TelehealthCOVID19/
http://www.apta.org/PTinMotion/News/2020/03/18/E-VisitFAQs/

For more information on e-visits please refer to the following CMS Fact Sheet:
https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

7. What diagnosis code should be reported for telehealth visits?

As always, your E/M codes must be supported by diagnosis codes that report symptoms or confirmed illness to establish the medical necessity of the service, and support the level of service. For patients under your care for chronic conditions that must be assessed, this is straight forward. For patients who have symptoms, just report the symptom codes.

8. What diagnosis code should I report if the telemedicine "visit" is COVID-19 related?

On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern. As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus.

- U07.1, COVID-19 (test confirmed) (valid 04/01/2020)

Without a positive test:

- Z71.84 Encounter for Health counseling related to Travel
- Z71.1 Person with feared health complaint in whom no diagnosis is made