

ACR Telehealth Provider Fact Sheet

With the outbreak of coronavirus disease 2019 (COVID-19), it is imperative to ensure rheumatology health services are available and telehealth is a viable option to treat patients. Telehealth will allow providers to complete assessments and treatments in the patient's residence that would otherwise need transport to the physician office or hospital.

On March 17, the Centers for Medicare & Medicaid Services (CMS) expanded access to telehealth services as part of the government-wide effort to ease the growing COVID-19 pandemic. The 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act included a provision to waive telemedicine restrictions for Medicare beneficiaries. Under the waiver CMS will reimburse telehealth visits at the same fee-for-service rate as regular, face-to-face evaluation and management (E/M) visits. Additionally, the Office of Civil Rights (OCR) will not impose penalties on rheumatologists and rheumatology healthcare professionals who use everyday communications technologies such as FaceTime or Skype that are noncompliant with regulatory requirements under the Health Insurance Portability and Accountability Act (HIPAA) during the nationwide pandemic.

Telehealth and virtual care solutions will:

- Improve access to care;
- Facilitate the timely diagnosis and treatment of rheumatic patients, while limiting the risk of person-to-person spread of the virus;
- Allow providers to communicate with patients anywhere and anytime;
- Track patient health status, and
- Provide timely interventions.

Below are coding guidelines to understanding the key concepts and regulations as a practical option for rheumatology professionals and practices to ensure proper reimbursement for telehealth services.

Events are evolving daily around COVID-19. The ACR will continue to make updates as they become available.

Practitioners Approved to Provide Telehealth

Distant site practitioners who can furnish and receive payment for covered telehealth services (subject to state law) are:

- Physicians;
- Nurse practitioners (NPs);
- Physician assistants (PAs);
- Clinical nurse specialists (CNSs);
- Clinical psychologists;
- Clinical social workers; and
- Registered dietitians or nutrition professionals.

Additionally, occupational therapists and physical therapists can furnish and receive reimbursement from CMS for telehealth and eVisits. eVisits are "non face-to-face patient-initiated digital communication that require a clinical decision that otherwise typically would have been approved in the office." Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).

For telehealth services, physical and occupational therapy services at all levels can be coded with CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97530 and 97535.

A growing number of other commercial payers have also endorsed occupational and physical therapists to provide telehealth and this will be updated as information is provided.

Licensing

With the declaration by President Trump of a national of emergency, the 1135 Waiver was enacted, a "waiver of provider licensure," While the provisions do include a waiver that allows authorized providers to render services outside their states of Medicare enrollment, in order for the provider license waiver to be of practical use, states will need to create their own licensure waivers because state requirements take precedence. However, many states are passing legislation related to licensure requirements. See "State Actions" for individual state licensure waivers. The ACR will continue to monitor state legislation on this issue and will update the state list as information is provided. [Review notice](#).

Telehealth Coding

Synchronous audio/visual visits should be billed using the regular office or other outpatient evaluation and management (E/M) codes:

- 99201 – 99205 New patient visits
- 99212 – 99215 Established patient visits
- 99241 – 99245 Consultation codes

Telephone Services

On April 30, CMS made a significant expansion with payment parity for **audio-only** telephone visits (99441-99443). The policy update increased payments for telephone visits to match reimbursement for similar office and outpatient visits. This change is retroactive to March 1, 2020.

CMS' first adjustment to their payment policy to reimburse for telephone services was made on March 30,2020 which allowed rheumatologists and rheumatology providers to provide virtual visits to patients. CMS previously required telehealth services to have both audio and visual elements; the ACR along with the AMA and other medical groups pushed the Agency to remove that requirement, arguing that some sessions can easily be conducted over the phone.

- 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 of medical discussion
 - 98968: 21-30 minutes of medical discussion

**Although the CPT descriptor states 98966-98968 services are for qualified non-physician health care professional, under the public health emergency, all providers can provide these services to established patients.

- 99441: Telephone evaluation and management service by a physician or other qualified healthcare 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

e-Visit Codes

This service is for digital or brief check-ins where patients can communicate through a patient portal but must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

- 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

Interprofessional Telephone/Internet/Electronic Health Record Consultations

- 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 of medical consultative discussion and review
- 99451: Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including written report to the patient's treating/requesting physician or other qualified healthcare professional; 5 – 10 minutes or more of medical consultative time
- 99452: Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified healthcare professional; 30 minutes

Virtual Check-Ins

Virtual check-in services can be reported for both new and established patients. This service is usually initiated by the patient and provided in their home with a brief communication service with providers via several communication technology modalities, including synchronous discussion over a telephone or exchange of information through video or image.

- 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.
- 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.

Modifiers

In most cases, billing for telemedicine looks similar to billing for in-person evaluation and management (E/M) services. The biggest difference is that you may need to add a modifier depending on the payer billing requirements. There are three potential modifiers that earmark a claim as telehealth: GT, GQ, and 95.

Commercial	Medicare & Medicare Advantage	Medicaid
<ul style="list-style-type: none"> • All CPT/HCPCS codes recognized by CMS payable as telehealth appended with modifiers GT, GQ or GO • Recognized by the AMA included in Appendix P of CPT and appended with modifier 95 	<p>All CPT/HCPCS codes payable as telehealth when billed with:</p> <ul style="list-style-type: none"> • Place of Service (POS) 11, and • Modifier 95, or • Catastrophe/disaster related (CR) modifier (providers will need to confirm with individual MACs) 	<ul style="list-style-type: none"> • POS 11 • All CPT/HCPCS codes recognized by CMS as payable as telehealth appended with modifiers GT or GQ • Recognized by the AMA included in Appendix P of CPT and appended with modifier 95 • Verify billing guidelines with state laws

As of March 31, CMS requires providers and rheumatology professionals to bill telehealth claims with POS 11 and modifier 95. Not all private payers require place of service (POS) 02/11 or a modifier to bill a telemedicine claim, so it will be necessary to verify with individual payers if a remittance advice is received indicating that the POS is incorrect. [View a full list of commercial payers temporary telehealth policies.](#) The ACR will continue to monitor and update CMS and private payer billing guidelines for telehealth as they develop during the national COVID-19 crisis.

Medicare Fee Schedule (Telehealth Services)

While the new provisions allow for greater flexibility for telehealth services, there are still questions regarding reimbursement of these services. The ACR along with other specialty societies will continue to advocate to CMS for temporary increases in fees to support practices during the coronavirus crisis.

CPT CODES	Descriptor	MDCR Fee Schedule
99201-99215	Office or other outpatient visits for new and/or established patients	Regular fee schedule
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	\$15.50

99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	\$31.01	
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21-30 minutes	\$50.12	
99441	Telephone evaluation and management service by a physician or other qualified healthcare 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	Fee Schedule	Revised Fee Schedule 4/1/2020
		\$14.41	\$46.19
99442	Telephone evaluation and management service by a physician or other qualified healthcare 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; 11-20 minutes of medical discussion	Fee Schedule	Revised Fee Schedule 4/1/2020
		\$28.15	\$76.15
99443	Telephone evaluation and management service by a physician or other qualified healthcare 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; 21-30 minutes of medical discussion	Fee Schedule	Revised Fee Schedule 4/1/2020
		\$41.14	\$110.43
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	\$18.39	
99447	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; 11-20 minutes of medical consultative discussion and review	\$37.14	

99449	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; 31 minutes of medical consultative discussion and review	\$73.93
99451	Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including written report to the patient's treating/requesting physician or other qualified healthcare professional; 5-10 minutes or more of medical consultative time.	\$37.51
99452	Interprofessional telephone/internet/electronic health record referral service(s) provide by a treating/requesting physician or other qualified healthcare professional; 30 minutes	\$37.51
99448	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; 21-30 minutes of medical consultative discussion and review	\$55.54

American Medical Association (AMA) CPT Editorial Panel Released a New COVID-19 CPT Code and Descriptor for Testing:

- 87635 - Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), amplified probe technique

COVID-19 Diagnosis Coding

On March 18, the ICD-10 Coordination & Maintenance Committee approved the provisional assignment of a diagnosis code for the coronavirus under "new diseases of uncertain etiology or emergency."

Effective April 1, 2020, the classification will be listed under ICD-10-CM:

- U07 - Conditions of uncertain etiology
 - **New code:** U07.1 – COVID-19
 - Use additional code to identify pneumonia or other manifestations

- Excludes 1: Coronavirus infection, unspecified site (B34.2)
Severe acute respiratory syndrome [SARS], unspecified (J12.8)

Private Payers

On March 17, UnitedHealthcare announced they will largely follow CMS's lead for billing and reimbursement for telehealth services. The UHC [Provider Telehealth Policies](#) will waive the CMS originating site restriction for Medicare Advantage, Medicaid, and commercial members, allowing providers to bill for telehealth services performed while a patient is at home. The policy change is effective until April 30, 2020. They will also permit the use of FaceTime/Skype with no enforcement of HIPAA restrictions for noncompliance. For video visits, UHC will reimburse providers at the same level as a regular E/M office visit. UHC will provide an FAQ on their website for additional clarification on telehealth services.

The ACR Insurance Subcommittee will continue to monitor each payer coding and billing guidelines and will update as the information becomes available.

Billing Telemedicine – Points to Remember

Key guidelines for billing telemedicine services:

- CMS will permit reporting of telehealth E/M office or other outpatient visits based on time or Medical Decision Making (MDM). Practices will need to verify with private payer on how to report E/M encounters.
- **Time:** Documentation for the encounter should include the required elements for each CPT code, such as MDM or time.
 - Time is defined as “all” the time associated with the E/M on the day of the encounter and, the current typical times associated with office E/M should be met for the purposes of level selection
- CMS is maintaining the current definition of medical decision making
- The video component required for telemedicine encounters can be billed using a standard CPT code with the Modifier -95 for private payers.
- Keep in mind it is very important to document how every telehealth encounter is conducted (e.g., Skype, audio, etc.)
 - **Example:** The documentation details a telehealth encounter with the patient on this date of service. *“Audio and video communications were used during this encounter to provide a face-to-face interactive encounter. Components of this encounter are a culmination of visual and patient-assisted findings.”*
- Inclusion of assessments using peripherals such as thermometers, oxygen saturation monitors, spirometers, blood pressure monitors, glucose monitors, etc., in the documentation will support the need for a certain number of required elements for the CPT code being used.
- In the “asynchronous” category (for e.g., emails, radiographs, and ultrasound studies), clinical information is supplied and considered at a later time.
- Effective March 31, POS 11 is to be used for all telemedicine services under Medicare during the COVID-19 public health emergency.

Telemedicine FAQs

Q: What services can be provided by telehealth?

A: During the emergency declaration, any physician service provided via telehealth will be reimbursed by CMS that falls under the regular in-person services normally provided in the outpatient office setting. View the CMS list [here](#).

CMS reimburses separately for other professional services that are commonly furnished

remotely using telecommunications technology without restrictions that apply to Medicare telehealth. These services, including physician interpretation of diagnostic tests, care management services, and virtual check-ins, are normally furnished through communication

Q: Will CMS enforce an established relationship requirement?

A: No, the Department of Health and Human Services will not conduct audits to ensure there is a prior relationship with a provider for claims submitted during the public health emergency.

Q: Can an NP/PA provide telehealth services?

A: Yes, under the public health emergency CMS states for services requiring direct

supervision by the physician or other practitioner that physician supervision can be provided virtually using real-time audio/video technology.

Q: Are HIPAA rules the same with telehealth?

A: HIPAA penalties will be waived. The HHS OCR will use its powers of discretionary enforcement to waive penalties for HIPAA violations against providers using non-secure communications platforms (including FaceTime and Skype) if they are serving patients “in good faith” during the nationwide health emergency posed by the coronavirus crisis. Read the full announcement [here](#).

Q: Can medication be prescribed using telemedicine?

A: Yes, providers will continue using the e-RX to send prescriptions to pharmacies for refills and new prescriptions.

Q: Do all telemedicine services have to be live encounters?

A: No. In 2018, Medicare proposed a new definition to expand payment for remote patient monitoring services. Broadly, remote patient monitoring is the remote collection of data that the patient either inputs manually or can be collected through a transmitter. That data is used for clinical flags, such as high blood sugar, low blood pressure, increased pulse, or a sudden spike or drop in weight. That patient monitoring can be used to ensure patient safety, patient wellbeing, and treatment adherence.

Coverage, payment, and other aspects of reimbursement for services related to the coronavirus and telemedicine are continuously evolving. The ACR will continue to release information as further updates are available.

Q: What is the difference between virtual check-ins and e-visits?

A: A virtual check-in pays professionals for brief (5-10 minute) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth. An e-visit is when a beneficiary communicates with their doctors through online patient portals.

Q: Are the telehealth services only limited to services related to patients with COVID-19?

A: No. The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient. This is critical due to the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Social Security Act.

Q: What is the reimbursement for telehealth services?

A: Medicare will reimburse the same amount for telehealth services as it would for regular face-to-face E/M services.

Q: How long does the telehealth waiver last?

A: The telehealth waiver will be effective until the public health emergency ends.

State Actions

California

- Guidance to Medi-Cal Managed Care Plans:
<https://www.dhcs.ca.gov/services/Documents/MMCD/COVID-19Memo.pdf>
- Behavioral Health Bulletins:
https://www.dhcs.ca.gov/formsandpubs/Pages/Behavioral_Health_Information_Notice.aspx
- Licensure waiver:
<https://www.gov.ca.gov/wp-content/uploads/2020/03/3.4.20-Coronavirus-SOE-Proclamation.pdf>

Colorado

Plans were directed to conduct outreach and education campaigns to remind enrollees of their telemedicine options and to provide telemedicine services to cover COVID-19-related in-network telemedicine services at no cost share.

https://drive.google.com/file/d/1_9Z6CVhzAxNNxUWBKeAfVHgfr3mXQB_T/view?inf_contact_key=2825_2f60b0e45481d432c387e674dd83

Licensure waiver:

<https://docs.google.com/document/d/1fqo3qm8QQZG5vnzYEKg0BA1FgEBH-rBpRnPy0WeCDTw/edit>

Connecticut

Licensure waiver

<https://portal.ct.gov/-/media/Coronavirus/20200323-DPH-order-allowing-outofstate-practitioners-to-render-temporary-assistance-in-Connecticut.pdf?la=en>

Delaware

Licensure waiver:

<https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/DEMA-and-DPH-Order-3.23.20.pdf>

District of Columbia

Medicaid Program Update.

https://coronavirus.dc.gov/sites/default/files/dc/sites/dhcf/release_content/attachments/DHCF-PRINTUFL_UF_DHCF-PRT-06_1038_001.pdf

Licensure waiver: <https://governor.delaware.gov/wp-content/uploads/sites/24/2020/03/DEMA-and-DPH-Order-3.23.20.pdf>

Florida

Licensure waiver: <http://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf>

Hawaii

Licensure waiver: https://governor.hawaii.gov/wp-content/uploads/2020/03/2003109-ATG_COVID-19-Supplementary-Proclamation-signed.pdf

Iowa

Licensure waiver: <https://medicalboard.iowa.gov/>

Illinois

The state board of Illinois was directed waive licensure requirements for out-of-state physicians providing telehealth services in Illinois.

<https://www.idfpr.com/News/2020/2020%2003%2030%20Guidance%20Out%20of%20State%20Physicians%20Using%20Telehealth%20in%20IL.PDF>

Kansas

Licensure waiver: <https://governor.kansas.gov/wp-content/uploads/2020/03/E.O.-20-08.pdf>

Massachusetts

Medicaid Managed Care Plans required to cover telemedicine and certain telephonic services as a means by which members may access all clinically appropriate, medically necessary covered services. <https://www.mass.gov/doc/managed-care-entity-bulletin-20-coverage-andreimbursement-for-services-related-to-coronavirus/download>

Missouri

The state of Missouri is waiving their state statute and authorized providers licensed in other states to provide telehealth cross state lines.

<https://content.govdelivery.com/accounts/MOIFP/bulletins/2825956?fbclid=IwAR04hJRzgS3PRpwLu6WGVHjJOG-ZGLGZTyMnwmSBeqx5bCIGC1IYHXP5RwI>

New York

Providers who submit a “self-attestation” form will be able to provide telemental health for people affected by disaster emergency for a time-limited period.

<https://omh.ny.gov/omhweb/guidance/use-of-telemental-health-disaster-emergnecy.pdf>

Texas

Allowing phone consults and easing some regulations.

<http://www.tmb.state.tx.us/dl/920E0677-1BAF-C306-781B-A570AD6795A1>

COVID-19 coding and billing resources

To view the complete the CMS telehealth announcement, visit

<https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

UnitedHealthcare will continue to publish updates at uhcprovider.com/covid19.

Visit the [AMA Resource Center for Physicians](https://www.ama-assn.org/practicing/your-practice/ama-resource-center-for-physicians) or download the [CPT Assistant guide](https://www.ama-assn.org/practicing/your-practice/cpt-assistant-guide).

For additional information on ACR COVID-19 and telehealth advocacy efforts, contact Amanda Wiegrefe at awiegrefe@rheumatology.org. For practice management and coding guidelines, contact Antanya Chung at achung@rheumatology.org.

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