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Emergency Rule: Docs Can Bill for Telehealth and COVID-19 Tests. Here's How

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Many medical practices have long wanted to use telehealth to perform office visits and other evaluation and management (E/M) services. The technology readily exists and many electronic health records are set up to do telehealth visits.

The problem has been getting paid for those visits. Medicare limited telehealth services to patients in underserved areas, and commercial insurances wouldn't pay. But amid the COVID-19 crisis, things have changed.

On March 17, Congress passed a law allowing Medicare to waive some telehealth restrictions only during a government state of emergency, which we are in now. Specifically, the patient no longer needs to be in a medically underserved area and no longer needs to go to an originating site, such as a hospital. The patient can be located anywhere in the country and be in their own home.

Further, CMS is waiving the requirement that the practitioner use a HIPAA-compliant platform for the telehealth service. The service must still be provided using a real-time audio/ visual platform, but that could be via FaceTime or Skype, both of which are readily available via a patient's smartphone or home computer. Audio alone —that is, phone calls between physician and patient —is still insufficient.

Billing for Telemedicine

There are two lists of services that you can bill for telehealth. One of the lists is in Medicare's telehealth fact sheet and includes both CPT and HCPCS codes. The second is in your CPT book, Appendix P, and lists only CPT codes.

Practices may bill all of the Medicare-covered telehealth services using these new rules. This includes new and established patient visits 99201–99215. It includes inpatient and skilled nursing services, for which CMS uses HCPCS codes in place of CPT codes.

Some notable additional services that you may bill via telehealth are: smoking cessation, transitional care management, advanced care planning, psychiatric diagnostic interviews and psychotherapy, and initial and subsequent Medicare wellness visits. The Welcome to Medicare visit is not on the list.

Report these services to Medicare with the correct CPT code and use place of service 02 (telehealth) on the claim. There is a CPT modifier for telehealth (Modifier -95 Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System) but Medicare does not require it.

If you perform an office visit and also do smoking cessation, document those just as you would if you saw the patient in person. Document the history; observational exam, if relevant; and the assessment and plan. Note the additional time spent in smoking cessation counseling. If it was a level three established patient, code 99213-25 and 99406 (smoking and tobacco use cessation counseling visit, intermediate, 3-10 minutes).

The Office of Inspector General (OIG) is allowing practices to reduce or waive copays and patient due amounts. However, a practice is *not required* to waive the copay or patient due amount for a telehealth service.

Medicare Advantage plans are required to cover all services that original Medicare covers. State Medicaid plans and Medicaid managed care organizations can set their own rules.

What About Commercial Payers?

While CMS has issued its Medicare guidelines, commercial insurance companies can also set their own rules about covering telehealth services. Many of them have rushed to update their policies to allow office visits to be billed via telehealth.

Unfortunately, each payer can set its own rules about whether to cover telehealth and if the place of service 02 and/or modifier -95 is needed. UnitedHealthcare is covering telehealth visits for all of its Medicare Advantage, Medicaid, and commercial accounts.

Humana is also covering telemedicine for urgent care needs. Some private insurers are continuing to offer virtual visits with their contracted telehealth provider, not with the patient's own physician. It is likely that this will change in the days ahead, but it means practices must check their payer policies and pay attention to the emails they receive from the payers. If patient foot traffic is slow, this may be a good time to call each payer to not only find out their telehealth rules, but to also learn what else is being suspended during the COVID-19 pandemic.

This would also be a good job for an employee to do from home versus coming into the practice.

None of the payers are limiting the diagnosis code for telemedicine services. The patient does not need to have a cough or fever to have telemedicine covered. Any diagnosis or condition is eligible to be billed via telehealth.

The waived restrictions by Medicare are in place only as long as the government state of emergency. Commercial payers are also describing these as temporary. However, it may be hard to put the genie back in the bottle. Medical practices and patients may find that these visits are just what the doctor ordered.

COVID-19 Testing

Although testing is still not widely available, the American Medical Association has developed a CPT code for the test:

- **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

CMS has also developed codes for testing for this new coronavirus. One (U0001) is specifically for tests done in the CDC lab. The second (U0002) was for other labs, but it seems likely that the CPT code will replace it.

In February, the US Food and Drug Administration issued a new policy for certain labs to develop their own validated COVID-19 diagnostics. This second HCPCS code could be used for such tests when submitting claims to Medicare or other insurers.

The hope by CMS is that having these specific codes will encourage further testing and improve tracking of the virus.

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