Billing telehealth under COVID-19 rules? Use POS 02, document need, watch payer shifts

by: Roy Edroso

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Coronavirus

You may be gearing up to offer patients telehealth services during the COVID-19 emergency since CMS waived the originating site requirements. If so, you may not be familiar with the requirements – and many of them have changed in the past few weeks. Make sure you code and document these claims so that they'll be accepted, and watch out for private payers who haven't adopted CMS' waiver yet.

By and large, you should observe all the documentation rules that always apply to the codes you're claiming. These codes include not only the e-visit and remote codes mentioned in the fact sheet CMS put out on March 17, but also the 101 Medicare telehealth service codes that are also freed up under the COVID-19 rules. (For a complete list of covered telehealth service under Medicare, access the downloadable file at https://pbn.decisionhealth.com/Articles/Detail.aspx?id=531236).

Both the regular office E/M codes (99201-99215) and the new online E/M codes (99421-99423) are cleared for your use as telehealth services by CMS. But there's a big difference in payment: The office E/M codes bill between $23.46 and $211.12, while the telehealth codes bill $15.52 to $50.16, according to national, non-facility payment rates.

Heather Macre, an attorney and director of the business litigation department at the Fennemore Craig law firm in Phoenix, Ariz., advises that you make your code selection based on the same standards as usual – that is, you should focus on what's most appropriate to the service rendered and what the provider's scope of practice meets.

"While some codes do pay at higher rates, they should only be selected when they are applicable and can be proven with the appropriate medical records documentation," Macre says. "This includes information on the complexity and the duration of the visit."

Though they may look similar, the services often have very different descriptions, says Tracy E. Weir, an attorney and shareholder with Baker Donelson in Washington, D.C.

For example, take the difference between an "e-visit" – the services covered by 99421-99423 as well as the qualified non-physician health care professional online assessment codes G2061-G2063 -- and an office E/M visit billed as telehealth. E-visits "are for communications initiated by an established patient through an online patient portal and the time spent by the clinician over the course of a seven-day period evaluating and addressing the issue raised by the patient," Weir says.

If you're doing a regular 99212 through a telehealth medium, it's still a 99212.

Use POS, not modifier, for Medicare

Macre reminds you that the place of service (POS) for telehealth claims is 02 – not your office POS (11) or other sites you may be providing services from. Modifiers for telehealth – GT and 95 – are not necessary for Medicare claims.

Bear in mind, though, that other payers may require those modifiers.

"We are definitely seeing private payers continue to tell physician to continue to use GT [or] 95, but not across the board," Macre says. "Physicians who have questions should check the private payer-provider updates they get or maybe make a call to the private payers. Billing companies should also be helpful on this issue."

Private payers may differ

What about non-government payers? Eric D. Fader, a partner with the Rivkin Radler firm in New York City, finds that large insurers have – for the most part – made accommodations for the emergency, but they vary and don't always match CMS' standards.

For example, CMS tells providers that while "beneficiaries are generally liable for their deductible and coinsurance … [OIG] is providing flexibility for health care providers to reduce or waive cost-sharing for telehealth visits paid by federal health care programs."

On the other hand, Aetna has waived cost-sharing for all telehealth services provided by "Teladoc options through the Aetna Health app' network providers who deliver virtual care, such as live video-conferencing; [and] other virtual care apps or services provided as part of your plan." Cigna has waived cost-sharing for "COVID-19 testing-related visits with in-network providers" specifically.

Bear in mind that some state actions will allow for more liberal use of telecommunications in that state than the feds will – though payment for those services is still up to the payers. The Texas Medical Board, for example, says that "telemedicine, including the use of telephone only, may be used to establish a physician-patient relationship. This expanded use of telemedicine may be used for diagnosis, treatment, ordering of tests and prescribing for all conditions. The standard of care must be met in all instances."

Contrast this with CMS, which only allows claims for "synchronous discussion over a telephone" to be billed with the virtual check-in codes G2012 (Brief communication technology-based service, 5-10 minutes) and G2010 (Remote evaluation of recorded video and/or images submitted by an established patient).

Especially if you're new to telehealth, be aware that regulations for private plans will differ from state to state as far as what insurers are required to cover, and at what rate, warns Jenny G. Givens, a partner at the Gray Reed firm in Dallas. "In Texas, TDI [the Texas Department of Insurance] requires insurers to reimburse telehealth encounters at same rate as in-office," she says. But "just because the state issues a regulation or guidance doesn't mean every plan has to follow. In Texas, only plans regulated by TDI are covered [by their regulation]." Self-funded plans, such as often cover employees of large companies, are not.

Buck the system?

What if your payer hasn't changed its telehealth policy and you believe, given the emergency, you should still be able to use – and claim payment for – telehealth services?

Fader thinks it's worth a try. "The practical thing is, if a claim's denied, you always have the ability to appeal. There may be some public policy pressure to permit things whether they're publicized or not."

Jan Dubauskas, vice president of the online health insurance brokerage HealthInsurance.com, suggests that you "work directly with your insurance company to negotiate coverage." If that doesn't work, she suggests working with a patient advocacy service, which regularly works with insurance companies to negotiate more favorable outcomes.

Harry Nelson, partner with Nelson Hardiman and author of The United States of Opioids: A Prescription for Liberating a Nation in Pain, is less optimistic. "On the one hand, payers are liberalizing [telehealth] -- but on the other side, they'll be getting an avalanche of claims, and there'll be lots of denials in those circumstances."

Nelson is currently running webinars for health care clients who have heretofore seldom or never used telehealth, such as providers of addiction treatment, autism treatment and behavioral health. "I tell my providers: Expect to have problems getting paid," he says. "There'll be big pushback from the payers from the sheer volume alone."

Down the road, though, especially after a protracted emergency situation, payers may begin to take the hint.

"I've been arguing for five years that the only way to meet some of the needs of our health care system is to treat in the lowest possible acuity setting," Nelson says. "We've been moving care away from hospitals, to ambulatory and office setting, and ultimately toward home. To me, telehealth is the ultimate realization of that logic. This has been a wake-up call and people are being forced to do it." – *Roy Edroso (redroso@decisiohealth.com)*

Resources

- CMS fact sheet: www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- CMS telehealth FAQ: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- OIG policy statement: https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf
- Aetna COVID-19 page: www.aetna.com/individuals-families/member-rights-resources/covid19.html
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