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How to Bill and Code for a Telemedicine Visit During the COVID-19 Pandemic

Video Transcript

Hello, my name is Sakina Bajowala and I'm a board certified allergist and immunologist and a member of the combined AAAAI/ACAAI Joint Task Force on Telemedicine. I've created this video to help our membership understand the nuances of billing and coding for telemedicine during the current public health emergency. As we all know, allergists have been significantly affected by stay at home orders across the country, which were designed to keep both staff and patients as safe as possible. This has required us to significantly cut down on in-person visits and transition a large proportion of the care we provide to virtual or telehealth services.

Luckily, payers including CMS and private payers have significantly expanded telehealth availability in terms of both coverage and payment during this time to increase access to patients and allow practices to maintain the care they provide for patients and still get reimbursed appropriately. However, it can be really confusing for allergists to understand exactly how best to bill for the services they're providing to ensure the optimization of reimbursement so they can continue practice operations. To that end, I'd like to take just a few minutes to go over some of the telehealth services that you can offer to your patients in an allergy and immunology practice and how best to bill and code for them. <The following text appears across the screen: All telehealth visits must have documented consent from the patient.>

We're going to start with the code G2012, which is a virtual check-in. <The following text appears across the screen: G codes were created for Medicare and may not be applicable to private payers.>

A virtual check-in code is designed to be a five to 10 minute phone call or video chat that is designed to help a patient determine if the issue they're currently experiencing warrants a full E&M visit via in person or via telemedicine visit. It's not meant to be an extensive evaluation and it can be performed with a staff member and not necessarily with the provider. <The following text appears across the screen: The patient must be seen by a physician, physician assistant (PA) or nurse practitioner (NP) to utilize this code.>

This is best billed using code G2012, using your usual place of service, which for an outpatient allergy clinic would be place of service 11 and no modifier is needed.

The next new code that has become available to allergists during the public health emergency is the remote review of images or video. An example would be if a patient sends images of a rash to you via your patient portal for you to review and give some opinion on, and that is done using CPT code G2010. <The following text appears across the screen: Interpretation of the image and follow-up with the patient within 24 hours is required when using this code.>

Once again, this is with the place of service—your usual place of service of 11 if you're an outpatient clinic—and no modifier is necessary.

Telephone care is something that historically has often gone uncompensated, or it's free care that many allergists have provided to their patients. However, during the current public health emergency, payers have recognized that for some patients who do not have access to mobile video technology, telephone care is the best way to deliver care safely. Therefore, they have agreed to reimburse the codes that have

already been established for telephone visits. <The following text appears across the screen: You cannot use telephone only codes if the call results in a decision to see the patient within 24 hours (or the next available urgent visit appointment).>

These are the codes that can be used for telephone visits: 99441, which designates a telephone visit with five to 10 minutes of medical discussion; 99442, 11 to 20 minutes; and 99443, 21 to 30 minutes. The place of service, as in the other codes I mentioned, is place of service 11—your usual outpatient code—and there should be no modifier necessary.

Next we come to kind of our meat and potatoes: a synchronous face-to-face video visit or what we commonly consider to be our telemedicine visits. <The following text appears across the screen: All telehealth visits must have documented consent from the patient.>

These are billed using your standard E&M codes that you would use for normal outpatient care. However, what's notable is that historically it has been very difficult to get insurance coverage for telemedicine delivered to new patients because many states and payers had requirements that a patient needed to be an established patient of the practice with a physical exam on file before telemedicine services could be billed. However, during the public health emergency this has been temporarily waived. So you now have the opportunity to provide care to your new patients via telemedicine. This is done using your standard new patient E&M codes 99201-5, using either time-based billing as I've designated here, or medical decision making.

For established patients, the rules are the same. Codes 99211-5 with either time-based billing, or medical decision making. Now, what's interesting here is that historically, what the place of service for telemedicine has been designated is 02, which designates telemedicine visits. However, many payers have historically reimbursed telemedicine care at a lower rate than live face-to-face visits, but during the current public health emergency payment parity has been enacted by many payers. And in order to simplify the billing and coding, the guidance from most payers has been to use the usual place of service—11, for example—instead of the 02 place of service, to guarantee payment parity and to optimize your reimbursement. You would then, while using place of service 11, use a modifier 95 or GT to designate the service as telehealth. This is not a uniform recommendation among all payers. Notably, TRICARE and Aetna and a number of state Medicaid plans still give the guidance to use place of service 02. The best way to know how best to bill is to reach out to your individual payer.

Finally, a new code that can be used during the public health emergency for most payers is the digital health evaluation or e-visit code. This is a code that you would use when a patient reaches out to you for medical guidance using a secure electronic means such as your HIPAA-compliant patient portal. Generally this must be initiated by the patient and not resulting from an existing E&M visit within the last seven days. And it also should not result in another E&M visit within the next 24 hours or the next available appointment. The interesting thing about billing for digital health evaluation or e-visit codes is that it is a cumulative time-based coding system over the course of seven days. So what you have to do is you have to add up the time that you spend in review, research and response for that one patient over the course of one week. Add it up and then bill for that cumulative amount of time once per week. These are the codes that you would use: 99421, for five to 10 minutes of cumulative time spent; 99422, for 11 to 20 minutes; and 99423, for greater than or equal to 21 minutes. As with most of the other codes, the place of service is your usual place of service 11 and there is no modifier necessary.

It's important to recognize that a lot of the telehealth expansion is considered temporary. However, most of the payers' telehealth expansions are still in place and may continue to be extended on an ongoing basis in line with CMS recommendations. So it's important to stay on top of your individual payers to make sure that you're billing appropriately according to their most current guidelines, and that your patients are also aware of what their financial responsibilities might be during this time.

I hope this has been helpful. Please stay tuned for future videos on how to optimize the offering of telemedicine to your patients.