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Telehealth Coding Guide for Billing

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MTELEHEALTH, LLC | 455 NE 5th Avenue, Suite D144, Delray Beach, FL 33483|
ph 561.366.2333 | fx 561-366-2332 | www.mTelehealth.com

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There's nothing more frustrating than rendering a service and not being paid. Nuanced coding rules are difficult to understand, and physicians aren't taught this information in medical school.

Still, health care is a business. As business owners, physicians need to know how they're paid, including what codes to use, what modifiers to append and what details to document. Brushing up on common coding mistakes helps avoid costly recoupments and denials. We've asked several coding experts to provide their best advice on how physicians can maintain compliance and collect all of the revenue to which they're entitled.

In part 1 of our two-part coding guide, we focused on coding for telehealth and other forms of remote patient care — important codes for physician practices' short-term survival as the U.S. continues to grapple with the COVID-19 pandemic.

Telephone services

In times of social distancing, telephone services have become a practical way to improve patient access and prevent spread of COVID-19. Telephone services are ideal for straightforward problems (e.g., simple rash, asymptomatic cough, medication refills) that require a minimum of five minutes of medical discussion, says Toni Elhoms, CCS, CPC, chief executive officer of Alpha Coding Experts, LLC, in Orlando, Florida. Consider the following codes that Medicare accepts during the current public health emergency (PHE). Commercial payers may accept these codes, as well. Note that once the PHE has concluded, Medicare may only accept G2012 (virtual check-in) for telephone services.

Elhoms provides these tips to ensure compliance:

- Document verbal consent, including patient acknowledgement and acceptance of any copayments or coinsurance amounts due.
- Only count time spent on the phone engaging in medical discussion with the patient or caregiver. Do not report these codes for conversations lasting less than five minutes.
- Clearly document what was discussed, as well as the outcome of the conversation (e.g., medications prescribed, referrals to specialists, additional steps for the patient to take).
- Don't report these codes when the telephone service ends with a decision to see the patient in 24 hours or the next available appointment.
- Don't report these codes when the telephone service relates to a related E/M service performed within the previous seven days or within the postoperative period of a previously completed procedure.
- Only provide 99441-99443 and 98966-98968 for established patients. During the PHE, Medicare permits providers to bill G2012 for new and established patients.

The best way to operationalize these codes is to set up an edit in the practice management system that pends claims for a manual review to determine whether and which services are ultimately billable, Elhoms says.

Telehealth services

In the last few months, providers have adopted telehealth to improve patient access and generate revenue during COVID-19. Among the services physicians can render via telehealth to patients with Medicare during the current PHE are Medicare annual wellness visits, new and established patient office visits, prolonged services, smoking and tobacco cessation counseling, annual depression and alcohol screenings, advanced care planning and more. Medicare covers more than 200 services via telehealth, many of which were added for temporary coverage during the current PHE. Commercial payer coverage of these services may vary, and it's best to check with individual payers, Elhoms says.

Elhoms provides these tips for billing telehealth services:

- Pay attention to audio-only vs. audio-visual requirements. Medicare requires the use of audio-visual technology for certain telehealth services and permits audio-only for others. Commercial payers also may have specific requirements. For example, physicians can render a telehealth visit for advanced care planning using audio only, but they must use audio-visual technology for a new patient telehealth office visit.
- Don't render Medicare's Initial Preventive Physical Exam via telehealth. Medicare does not permit it.
- Document verbal consent for telehealth, including patient acceptance of any copayments or coinsurance amounts due.
- Use place of service (POS) code 11 and modifier -95 when billing Medicare. Note that commercial payers may require a different POS code (e.g., POS 2 or POS "other") and modifier.
- Document, document, document. Physicians need to prove they met all of the code requirements even when rendering the service via telehealth, Elhoms says. "Don't pull in a problem list if you didn't treat or manage all of those problems," she adds. "Physicians need to link the diagnosis with the assessment and treatment plan. That's imperative." One caveat is that during the current PHE, physicians can bill 99201-99215 rendered via telehealth based on time or medical decision-making. "The total time in direct medical discussion with the patient is going to be critical," Elhoms says.

"The best advice I can give anyone doing telehealth right now is to watch the CMS [Centers for Medicare & Medicaid Services] and commercial payer websites pretty much on a daily basis," says Rhonda Buckholtz, CPC, CPMA, owner of Coding and Reimbursement Experts in Pittsburgh, Pennsylvania . "The coding of services changes constantly, and practices really need to be careful."

Online digital E/M services

Though online digital E/M services are relatively new, they also can help practices increase patient access during COVID-19. Here's how it works: An established patient initiates a conversation through a HIPAA-compliant secure platform (e.g., electronic health record portals, secure email, secure texting). A physician or other qualified health care professional reviews the query, as well as any pertinent data and records. Then they develop a management plan and subsequently

communicate that plan to the patient or their caregiver through online, telephone, email or other digitally supported communication.

Elhoms provides these tips to maintain compliance:

- Use these codes when physicians or other qualified health care professionals make a clinical decision that would otherwise occur during an office visit. Do not use them for scheduling appointments or nonevaluative communication of test results.
- Use these codes only for established patients.
- Do not use these codes for fewer than five minutes of E/M services.
- Document verbal consent, including patient acknowledgement and acceptance of any copayments or coinsurance amounts due.
- Do not report these codes when the online digital E/M service ends with a decision to see the patient in 24 hours or the next available urgent visit appointment.
- Do not report these codes when the online digital E/M service relates to a related E/M service performed within the previous seven days or within the postoperative period of a previously completed procedure.

Promoting these services is often the biggest barrier, says Elhoms, who suggests putting up signs letting patients know they can access their provider electronically for nonurgent medical issues.

Remote patient monitoring

Remote patient monitoring (RPM) is a relatively easy way for physicians to keep tabs on patients without requiring them to come into the office. Medicare covers RPM for patients with one or more acute or chronic conditions, and commercial payer coverage may vary. During the PHE, physicians can initiate RPM on new and established patients. Normally, Medicare permits it only for established patients.

RPM consists of two forms: monitoring data through either a non-manual or manual data transfer, says Jim Collins, CPC, CCC, consultant at CardiologyCoder.com, Inc. in Saratoga Springs, New York.

For example, physicians can remotely monitor a patient's pulse oximetry, weight, blood pressure or respiratory flow rate using a device that transmits daily recordings or programmed alerts. Physicians can purchase them directly from manufacturers or patients can purchase the devices themselves. Collins says patients should look for Bluetooth-enabled devices or ones that include a built-in Global System for Mobile Communications (GSM) transmitter. The former requires an Internet connection, and the latter automatically transmits data to an internet cloud service through an encrypted bandwidth. Physicians can bill for the initial setup, cost of the device itself (when applicable) and data monitoring.

Another example is self-measured blood pressure monitoring. When patients supply their own blood pressure device that a physician calibrates, physicians may be able to bill for patient education, device calibration, reviewing the data that the patient provides and communicating a treatment plan to the patient or caregiver.

"Monitoring physiologic data on a regular basis substantially reduces hospitalizations, trips to the emergency room and exacerbations of chronic conditions," says Collins. "It can also be a huge chunk of revenue."

Collins provides these tips for compliant RPM billing:

- Document patient consent. Patients must opt in for these services.
- Document total time spent rendering these services to support time-based requirements.
- Know when these codes are appropriate. It's unclear whether Medicare will pay physicians for monitoring physiologic data derived from internal devices (devices placed within the patient's body) or data derived from wearable fitness devices.
- Only bill 99457 when the provider renders at least 20 minutes of live, interactive communication with the patient or caregiver. "It's not going to be medically necessary to spend 20 minutes every month on every patient," Collins says. "Patients could go for several months without physicians needing to do anything for them."