Telehealth, Coding and Billing Guidance for 2021

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Introduction

As we navigate these challenging and uncertain times, Kareo understands the importance of working together with our independent practice clients and billing company partners to assist however we can. Kareo is committed to supporting your business and providing educational resources to help you to be successful. The mission of this guide is two-fold – to update you on telehealth changes for 2021 aand to answer questions you may have on this important topic. For additional information on billing code updates for 2021, click here.

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1.1 CMS Regulation Update

Expanded Telehealth Regulations

The goal of the expanded regulations during the national emergency is to get needed medical care to Medicare beneficiaries with as little travel as possible, allowing them to shelter in place.

The changes include:

- The patient does not have to have an established relationship with the provider as before, unless the code is specifically for established patients.
- Patients may live in urban settings, instead of only in a rural setting as before. There are no restrictions on provider distance from the patient.
- The patient may be at any originating site instead of a certified healthcare facility, which includes a patient's home.

Beneficiary Cost Share

Many of the Stark laws have been waived again to ensure Medicare beneficiaries are receiving needed care. Allowable costs are paid at 80% by Medicare Part B and the patient is responsible for 20%. Most often, the patient has Medicaid or supplemental insurance that pays their portion of the cost. But if the patient doesn't have the added insurance, providers now have the option to waive cost share for non-COVID-19 care, if it helps ensure patients receive care. The provider can choose to write off the costs because Medicare will not pick up the costs. Remember, COVID-19 care will be 100% covered by Medicare with no patient co-insurance and this change is waived only during the pandemic.

Medicare Advantage

Med Advantage plans are encouraged by CMS to cover all possible services via telehealth that can be provided safely and providers can also waive cost sharing. They must cover COVID-19 testing and care without patient cost share.

Medicaid

Medicaid already has broad telehealth authority so it remains largely unchanged. Providers will be covered for providing as many services as they can safely provide through telehealth. There also were no geographic or site restrictions. The only change would be if Medicaid says they want to restrict their telehealth services or their reimbursement for telehealth services to be different from in-person services. In that case, they would have to get permission from CMS.

Practice Rules

Medicare is using the same approved provider list for telehealth. Note that you may want to ignore the fact that Medicare says it will cover cross-state line telehealth services. For example, a provider in Iowa wants to provide telehealth care to a patient in Nebraska, but is only licensed in Iowa. While CMS says that would be covered, the reality is that states have not come out and said they are waiving licensing for the practice in that instance and it may violate state medical practice law. In addition, the provider may not have malpractice coverage in the other state.

Providers do not bill Medicare directly for services but bill a Medicare Administrative Contractor(MAC), with multiple contractors around the country. Here is what is new with MACs:

- The MACs are creating enrollment hotlines to expedite enrollment, both for practice locations and providers.
- Instead of going through PECOS to do enrollment, providers will use new MAC enrollment hotlines. Check the MAC websites for publication of an enrollment hotline number to expedite provider and location enrollments.
- CMS is going to waive certain screening requirements, such as onsite inspections, to make the enrollments go faster. If a provider wants to change their location long term, they need to

enroll their home or alternate office and it will get expedited. Medicare allows for a short-term location change (a few weeks up to a few months) to provide telehealth services and they can still report they are working from the office.

In Consideration in COVID-19 Legislation

CMS is covering 85 additional CPT codes via telehealth and they are considering whether they will cover telephone calls. Sequestration was removed and extended to March 31, 2021, which gave providers a 1.6 % bump. RHC and FQHC may be approved to be telehealth distant sites. Home health and hospice providers may provide expanded telehealth services. Watch for congressional updates to see if there are further extensions.

1.2 Coronaviruses

It is important to understand what the coronavirus is, and the underlying medical information behind what is being billed. Coronavirus is the umbrella term for a family of viruses - similar to influenza each year. There are seven known coronaviruses that infect humans, similar to influenza A, B, etc. The first four strains do not cause serious disease. The last three are the dangerous ones - MERS, SARS and COVID-19. Following is a list of each virus and the disease it causes (in parentheses). The one we are dealing with now is coronavirus severe acute respiratory syndrome 2 (**SARS-CoV-2**), which **causes** coronavirus infectious disease **2019 (COVID-19**).

A novel virus is a new virus that has crossed the species barrier. The reason this is serious is because no human has any anti-bodies created to prevent infection from the virus, causing wide-spread infection. Similar, though fortunately less severe, epidemics occurred when MERS-CoV and SARS-CoV arose.

Coronavirus – Virus Family (crown-like spikes on the virus surface)

1. 229E
2. NL63
3. OC43
4. HKU1

5. MERS-CoV (causes MERS)
6. SARS-CoV (causes SARS)
7. SARS-CoV-2 (causes COVID-19)

1.3 ICD-10-CM

U07.1 2019-nCoV acute respiratory disease

U07.1 is a temporary code. Most likely it will become a permanent code but for the latest guidance, check here.What you need to know:

- Temporary code: **AKA COVID-19**
- Created by the World Health Organization (WHO)
- CM approved by the cooperating parties
- Published by CDC

Non-COVID-19 Coronavirus Diagnosis Codes

These are the current coronavirus codes available. Given the severity of the novel coronavirus, it would seem a new family of codes would follow.

- **B34.2** Coronavirus, unspecified
- **J12.81** SARS associated pneumonia
- **B97.21** SARS in another disease

U07.1 2019-nCoV acute respiratory disease

As with all ICD-10-CM codes, do not assign U07.1 without a positive test. Also do not assign B34.2 as this is an unspecified site code, while SARS-2 is always a lower respiratory infection.

You would assign U07.1 when the patient has no associated disease.

In response to the continued COVID-19 public emergency, CMS announced additional COVID-19 codes that became effective January 1, 2021. These codes are:

- Encounter for screening for COVID-19 (Z11.52)
- Contact with and (suspected) exposure to COVID-19 (Z20.822)
- Personal history of COVID-19 (Z86.16)
- Multisystem inflammatory syndrome (MIS) (M35.81)
- Other specified systemic involvement of connective tissue (M35.89)
- Pneumonia due to coronavirus disease 2019 (J12.82)

Office Visits

When the patient presents for testing or with a differential diagnosis, assign symptom codes:

- SARS-CoV-2 testing
- Influenza v SARS-CoV-2 differential

Code patient's symptoms

Common symptoms include, but are not limited to:

- R50.9 Fever, unspecified
- R05 Cough
- R53.83 Other fatigue
- R06.02 Shortness of breath

Known/Possible Exposure to SARS-CoV-2

Utilize these personal history codes when these exposure situations apply:

Patient exposure to person with diagnosed SARS-CoV-2

- Z20.828 Contact with and (suspected) exposure to other viral communicable diseases

  Patient possible exposure to person with diagnosed SARS-CoV-2, ruled out after exam
- Z03.818 Encounter for observation for suspected exposure to other biological agents

ruled out

Pneumonia due to COVID-19

These coding scenarios are specifically described by the CDC when COVID-19 causes other respiratory illness, First diagnosis:

- J12.89 Other viral pneumonia
- Second diagnosis
- B97.29 Other coronavirus as the cause of diseases classified elsewhere

Bronchitis due to COVID-19

These coding scenarios are specifically described by the CDC when COVID-19 causes other respiratory illness:

Acute Bronchitis

- First diagnosis
    - J20.8 Acute bronchitis due to other specified organisms
- Second diagnosis
    - B97.29 Other coronavirus as the cause of diseases classified elsewhere

Bronchitis not specified as acute or chronic

- First diagnosis
    - J40 Bronchitis, not specified as acute or chronic
- Second diagnosis
    - B97.29 Other coronavirus as the cause of diseases classified elsewhere

ARDS due to COVID-19

These coding scenarios are specifically described by the CDC when COVID-19 causes other respiratory illness:

- First diagnosis
    - J80 Acute respiratory distress syndrome (ARDS)

- Second diagnosis
    - B97.29 Other coronavirus as the cause of diseases classified elsewhere

1.4 CDC Guidance Resources

Coronavirus Disease 2019 (COVID-19) | CDC

ICD - ICD-10-CM - International Classification of Diseases, Tenth Revision, Clinical Modification

Announcement New ICD 10 code for coronavirus 2 20 2020

Interim advice for Coronavirus Feb 20 2020

1.5 Procedure Codes

SARS-CoV-2 Testing

HCPCS Codes

U0001 is only for the CDC-created panel and U0002 is for any other panel

U0001 - CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

U0002 - 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) any other test -using any technique, multiple types or subtypes (includes all targets)

CPT Level I Code 87635 (Refer to Section 2.1 for additional information)

This code is for any panel. Currently, we know Medicare accepts the U codes. If you are a CLIA-certified lab, check with your payors regarding what codes they want used for proper billing. For additional code updates, visit this website.

Long descriptor

- 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

Medium descriptor

- IADNA SARS-COV-2 COVID-19 AMPLIFIED PROBE TQ

Short descriptor

- SARS-COV-2 COVID-19 AMP PRB

1.6 Telehealth Billing

Sites (Refer to updates in Sections 2.1 and 2.0 for additional information)

The CMS considers the "originating site" for telehealth billing as the place where the patient is located during the visit. Conversely, the "distant site" is the provider's location, which may seem counter-intuitive. Here is what you also need to know:

- Code Q3014 is only billed if the patient uses a facility for their end of the telehealth service. That code can only be used by the facility and includes the time, space and any operational expenses used for the telehealth visit. The visit could be at a nursing home or other healthcare facility. The provider would not use the Q3014 code, but use the procedure code for being the distant site.
- You would not use Q3014, which is often referred to as the "telehealth" code, to cover a phone call or additional services provided. It is only to cover the facility the patient used for a telehealth visit. This code would not be used if the originating site is a patient's home.

Telehealth Signifiers

A payer will want to use the telehealth POS (Place of Service 02), which is the designated place of service (but you may not always use) or a telehealth modifier (see below) - but never both.

- Category I modifier 95
- Category II modifier GT synchronous telehealth -- this means live video
- Category II modifier GQ asynchronous telehealth - this means you are sending recorded videos back and forth with patient, or radiology films are being sent and the provider is reading them and sending back

Medicare (Refer to updates in Sections 2.1 and 2.0 for additional information)

Medicare wants a CPT service code based on the patient's location, such as a home service visit, or an assisted living code, or a nursing services code. Use the provider's location for the billing service location and POS 02. No modifier is needed. Bill as though the patient was seen in person.

Again, the service location is the physical location of the patient. By billing with POS 02, the provider is certifying that the patient is at an eligible originating site or during the pandemic, at any site. Claims should be submitted to the MAC that processes claims for the performing provider's service area.

Common Codes

Many additional codes have now been added to represent the patient's location, which is the service location as we mentioned earlier. Many states have telehealth reimbursement parity laws, which means that most commercial payers will reimburse the same rate for telehealth as they do in-person services. We recommend printing out the Medicare MLN Matters Telehealth Guidelines here and highlighting the information that applies to your practice and using it as a guide - it will be very helpful.

Non-Medicare Payers

Non-Medicare/commercial payer policies vary widely and tend to be less restrictive than Medicare. Many major payers have COVID-19 interim policies as well as Medicare. You need to look at each payer and see what they want - typically they don't care how you provide your care as long as it doesn't affect how you bill for it.

When ready to submit claims, do not select one telehealth billing system and bill "payer blind". Rather, research the policies of your major payers and create a billing grid to keep handy during billing. Telehealth billing now is like the wild, wild west and if a claim is rejected, it is important to remember that the provider/billers are the experts for their practice and should always refer to the most current policies of a payer - you can ask them or find it on their website if needed. Also keep in mind:

- Most consider the provider location as the service location
- The modifier use varies, sometimes GT or 95
- To check each payer and ask for their written policy

Clearinghouses & Requirements

If not using Kareo and Trizetto, ensure your systems are ready to handle telehealth requirements and the new COVID-19 codes. Watch for any increase in rejections/denials. Make sure your clearinghouse is set up for telehealth. You should know where the rejection is coming from such as the system level, clearinghouse or at the payer level. As always, you should be the expert for your practice. Have copies of policies in writing and be ready to support what you billed. Some things to look for in submitted a claim:

- Is the modifier required on both lines?
- Does your system only allow the modifier on the primary code?
- Does your clearinghouse or code check system stop required modifiers?
- Watch for rejections/denials – determine in-house system, clearinghouse, payer level issue

Medicare Telehealth Guidelines

This link may change frequently as Medicare updates their policies during the emergency

Medicare MLN Matters Telehealth Guidelines: Telehealth Services

Commercial Payer Telehealth

Many major payers are adding COVID-19 interim policies for telehealth. Keep checking your major payers for policy updates.

Aetna COVID-19 telehealth information

What you need to know about the coronavirus (COVID-19) Aetna Providers

Humana COVID-19 telehealth information

COVID-19 Telemedicine

UHC telehealth information

Telehealth and Telemedicine Policy - Reimbursement Policy - UnitedHealthcare Commercial Plans

Telephone Billing

Telephone services need to stand alone to be covered. Review your major payers to confirm if they cover these services or just through the pandemic. Be aware of any change in rules.

For CPT reporting rules for Telephone - CPT does require the patient to initiate the service, in that they ask the provider to call them. The patient also must initiate the call and must be established to the practice. There must also be no visit in the last 7 days, next 24 hours or next available appointment.

Medicare is now going to cover the service. The telephone service CPT codes are:

- **99441** 5-10 minutes
- **99442** 11-20 minutes
- **99443** 21-30 minutes

Online Digital Services

The CPT reporting rules for digital services might include a secure chat or texting app. Extended social time spent with the patient does not count, only medically necessary time. This includes talking through a patient portal, secure email, other secure digital applications The codes are a cumulative code and includes all time spent in communication during 7 days by physician or other QHP. This includes evaluation and management services.

Remember that this does not include social interaction or scheduling and cannot be followed up with an in-person or telehealth service within 7 days.

Online Digital Services CPT Codes

If the service does not total at least 5 minutes, it is not reported.

99421 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

Medicare National Physician Rates

99421 $ 15.52

99422 $ 31.04

99423 $ 50.16

EHR Can Help In Connecting with Patients

With fewer patients coming into your practice now due to the coronavirus, it is important to keep a connection to ensure they come back after the crisis has passed. Technology in your EHR (especially those that are 2015-certified) can help you achieve that goal and stay connected to your valued patients, particularly older patients who probably need outside connection more than ever. Here are some ways technology can help:

Telehealth

Does your current EHR offer a telehealth option, which allows you to conduct HIPAA-compliant video visits? These visits are fully reimbursable and increases access to care for treatment plans and managing medications. It also offers scheduling flexibility and keeps patients and staff safe and healthy while the world battles the contagious nature of the coronavirus.

Chart Alerts

Some EHRs give you the option to send out chart alerts such as reporting that a patient has respiratory symptoms or is a high-risk patient, for example. It can alert that the patient needs social support regarding isolation protocols - such as access to a food bank or home health services.

Portal Broadcast Reminders

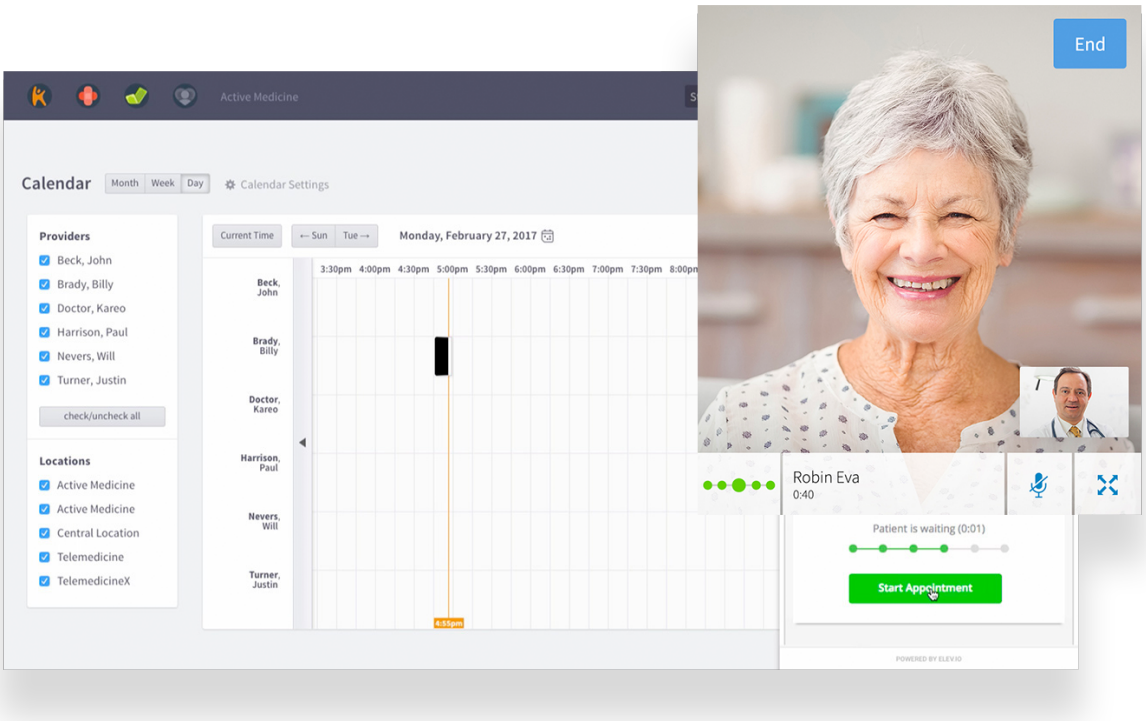
Some EHRs can send out broadcast reminders to their entire patient population or segments to notify everyone of what to look for in COVID-19 symptoms and when to do a screening. A practice can also announce that telehealth services are now available and/or if the practice has changed or reduced

hours. These reminders can tell patients to delay wellness and non-urgent visits and discuss COVID-19 hygiene.

Direct SMS Messages

Lastly, an updated EHR has the option for a practice to deliver direct SMS messages reminding a patient of upcoming appointments, office announcements and care reminders

All these communication options, which are available through some EHRs, while important before --are even more appreciated now by your patients. Most patients are feeling uncertain and fearful about the current state of the nation regarding COVID-19 and hearing from their doctor in one way or another, may help reduce their concerns, even if just a bit.



Did you know 62% of patients want to be able to directly communicate with their doctor?

There's never been a better time to implement an efficient and effective, HIPAA-compliant telehealth solution. With seamless integration to the Kareo EHR and Practice Management software, you can start virtualizing your practice today. **LEARN MORE**

Section 2.0 Updates From May 7, 2020

As we navigate these challenging and uncertain times, Kareo understands the importance of staying up to date with the most relevant information, and so we've done our best to incorporate those updates into this guide for you. Please note that things may change, but here are the updates as of May 7, 2020.:

1. Two additional COVID-19 testing codes were added to the CPT:
    a. These new codes complement the initial CPT code 87635, which is reported for multi-step qualitative nucleic acid testing.
    b. 86328 Immunoassay, qualitative, single step method (eg, reagent strip); COVID-19
    c. 86769 Antibody; COVID-19
2. CPT and Place of Service (POS) codes:
    a. POS code 02 reimburses at lower facility rate
    b. Under Public Health Emergency (PHC), telehealth will be reimbursed now based on the patient's actual location and POS to enhance reimbursement rates.
    c. Do not report POS code 02 to Medicare during PHE
    d. During the PhE, use the CPT and E&M code series and POS code corresponding to the patient's physical location
    e. Home visit codes are 99341-99215 and POS 11
    f. Assisted living facility visits are 99324-99337 and POS 13
    g. Office visits are 99201-99215 and POS 11
    h. To inform Medicare that it was a telehealth service, append modifier -95 to the service.
3. Billing service location:
    a. The service location, regardless of the patient's location and the E&M code series used, is now the provider's service location
4. Documentation requirements. Be sure to include in the clinician's notes the following items:
    a. Service was performed via telehealth
    b. Location of the patient

c. Consent of the patient for the visit to be completed via telehealth
d. The names of other people present during the visit
e. Consent of the patient for those people to be present during the visit

5. Telehealth Note templates:
    a. Impact: Allow for providers to easily identify a Telehealth Visit from the patient note
    b. Titles
        i. Telehealth H&P
        ii. Telehealth SOAP

Primary Care-focused templates content in the Subjective, ROS, Exam and Plan headings

        iii. Telehealth - Back Pain
        iv. Telehealth – Influenza
        v. Telehealth – Cellulitis
        vi. Telehealth – Constipation
        vii. Telehealth - Contact Dermatitis
        viii. Telehealth - Cough
        ix. Telehealth - COVID-19
        x. Telehealth – Diarrhea
        xi. Telehealth – General
        xii. Telehealth – Influenza
        xiii. Telehealth - Nausea, Vomiting
        xiv. Telehealth - Pharyngitis, Adult
        xv. Telehealth – Sinusitis
        xvi. Telehealth - URI, Common Cold
        xvii. Telehealth - UTI, Adult, Female
        xviii. Telehealth - UTI, Adult, Male
    c. Limitations: Exam/Objective template content does not reflect a Telehealth physical exam

6. Telemedicine - Updates for Telephone only calls:
    a. When using billing codes 99441-99443, Medicare will now reimburse at the same rates at E&M visits during the PHE.

b. These are not considered telehealth, do not append modifier 95
c. Report the provider's usual billing service location with POS 11
d. Include in the documentation, the service was performed via telephone and the minutes spent in evaluation and management

7. Links to Additional Information
    a. Medicaid telehealth billing
    b. COVID-19 Related State Actions
    c. Commercial COVID-19 Coverage
    d. Final Interim Rule
    e. CMS Med Learn Matters Telehealth Booklet

Section 2.1 Updates Prior to May 7, 2021

Because the telehealth billing codes and regulations are evolving through the COVID-19 pandemic, here are the updates that were provided as of March 30, 2020:

8. Medicare added 85 new codes that are covered via telehealth. A complete list can be found here - CMS adds 85 more Medicare services covered under telehealth Medicare added 85 new codes that are covered via telehealth. A complete list can be found here - CMS adds 85 more Medicare services covered under telehealth
9. Medicare will now cover the telephone services codes, 99441-99443.
10. The Stark laws have largely been waived to allow for the best placement of the healthcare workforce and healthcare equipment. This includes allowing for sharing of equipment required for telehealth services.
11. Providers in RHCs and FQHCs may be distant site providers and provide telehealth services.
12. Home health and hospice providers may provide expanded services.
13. The latest supplemental legislative package amends the restriction on telehealth services that requires a physician to have an existing relationship with the patient to be eligible for telehealth reimbursement. It was announced on March 17, 2020, that the CMS would not enforce that requirement, stating the CARES Act codifies the CMS policy, stating that a

physician is not required to have that treatment relationship with the patient to be reimbursed for telehealth services for the duration of the emergency period.

14. The CARES Act is supporting the use of telehealth technologies for services relating to mental health, at-home care, and preventive care in rural and underserved communities by providing $29 million per year for four years for a HRSA grant program available to practices..

Please stay up to date, by checking in on government resource websites, many of which can be found on our website. Kareo has also put together a list of COVID-19 resources on our website to assist you during the COVID-19 crisis.

Section 2.2 Commercial and Medicaid Telehealth Billing Coding Charts

The following tables include a sampling of billing guidelines for major national payors and Medicaid and other major payers in six states.

1. Major National Payers

Payer	Billing Address	POS	Modifier
Aetna	Provider Service Location	02	GT or 95
Anthem	Provider Service Location	02	GT or 95
Cigna	Provider Service Location	02	95
Humana	Provider Service Location	Based on patient location (11, 12, 13, etc)	95
UnitedHealthcare	Provider Service Location	Based on patient location (11, 12, 13, etc)	95

2. Illinois

Payer	Billing Address	POS	Modifier
Medicaid	Provider Service Location	02	GT
BCBS of Illinois	Provider Service Location	Based on Provider Location, or as the office would usually report (11, 21, etc)	GT or 95
Health Alliance Medical Plans	Provider Service Location	Telehealth services just during the PHE – Based on Provider Location, or as the office would usually report (11, 21, etc) Services previously reported with POS 02, continue to report with 02	Telehealth services just during the PHE 95 Services previously reported with POS 02, no modifier

3. Pennsylvania

Payer	Billing Address	POS	Modifier
Medicaid	Provider Service Location Bill the same as in person visits	Based on Provider Location, or as the office would usually report (11, 21, etc)	None
Capital Blue Cross	April 1 – May 31 Provider Service Location June 1 and after Provider Service Location	As the office would usually report 02	95 None
Highmark	Provider Service Location	02	95 or GT
Independence Blue Cross	Provider Service Location	02	95 or GT
UPMC Health Plan	Provider Service Location	02	95 or GT

4. California

Payer	Billing Address	POS	Modifier
Medicaid	Provider Service Location	Based on Provider Location, or as the office would usually report (11, 21, etc)	95 or GT
Blue Shield of California	Provider Service Location	02	95

5. Florida

Payer	Billing Address	POS	Modifier
Medicaid	Provider Service Location	02	GT
Florida Blue	Provider Service Location	02	95 or GT

6. Washington

Payer	Billing Address	POS	Modifier
Medicaid (Apple Health)	Provider Service Location	02	GT
Premera	Provider Service Location	Based on Provider Location, or as the office would usually report (11, 21, etc)	95 or GT
Regence	Provider Service Location	02	GT

7. Texas

Payer	Billing Address	POS	Modifier
Medicaid	Provider Service Location	Based on Provider Location, or as the office would usually report (11, 21, etc)	95
BCBS Texas	Provider Service Location	02	95 or GT

Section 3: Your Questions Answered on Telehealth Services and Billing During COVID-19 CRISIS (FAQ)

3.1 Codes

Q: How do you bill G2012? What is the POS?

A: G2012 is billed similarly to 99421. See applicable slide for details. The POS is 11. It is similar to other non face-to-face services taking place in the office. It is not a telehealth service, so POS 02 would not be correct.

Q: Are dialysis services provided in-unit allowed to be billed under telehealth (i.e. Code 90960)?

A: All codes that can be billed via telehealth are included in the Medicare MLN Booklet Telehealth Services. 90960 is a valid telehealth code. Be sure to follow the ESRD telehealth requirements.

Q: Would we use regular E&M codes 99201-99215 for just voice calls and Facetime?

A: Use E&M codes appropriate to the patient's location for Facetime or other live, synchronous video such as home visit codes 99341-99350. Voice calls should be reported with the telephone codes 99441-99443 when covered by the payer.

Q: What is the difference between a telephone code and a digital code?

A: A telephone code is for an actual telephone call between the provider and the patient. A digital code is for secure email, communication via the patient portal, or other secure online communication.

Q: What is the difference in billing 99201-99215 or 90832-90838 codes?

A: Report 99201-99215 when evaluation and management services to diagnose and/or treat a disease are rendered. Report 90832-90838 when psychotherapy services, also described as talk therapy, are rendered.

Q: What code is used for swab tests? Can you bill 99211 for this?

A: Bill the appropriate E&M code for the service. There is no separate code for swab collection. If the payer separately covers 99000 lab handling, you may be able to report that service. You may also have an agreement with your lab service to bill the lab service for the swab collection. If all that is performed during the service is a swab collection for COVID-19 incident-to the services of a physician or other qualified non-physician practitioner, it may be appropriate to report 99211 for the service.

Q: Can any type of practitioner use these billing codes, such as Acupuncturists or Chiropractors?

A: It wasn't clear to what codes the question was referring, so I'll try to cover a couple of options. All providers that may bill Medicare for telehealth services are included in the Medicare MLN Booklet Telehealth Services. These provider types are not currently included. Codes such as telephone codes and digital codes include in the description that the provider must be able to report E&M codes. Medicare and other payers require the provider to be working within their state scope of practice when reporting services. Thus, most of these

codes are not generally reported by acupuncturists or chiropractors beyond a lower level code. Please check your state scope of practice and payer specific rules.

Q: For commercial insurances, do we still use POS '02' for 99201-99215?

A: Commercial payers vary widely regarding their requirements for telehealth billing. Please check your payer telehealth policies to ensure clean billing.

Q: Do you know if NF providers can see patients with code 99307-99310 more than one time a month for telehealth?

A: Providers seeing a nursing home patient may only report subsequent nursing services via telehealth once per month. Other services might be reportable, such as psychotherapy, case management, or other care, but only one 99307-99310 may be reported per month.

3.2 Kareo-Specific Questions

Q: Kareo doesn't allow us to list the patient's physical address on POS home. How will we do that on POS 02?

A: If the patient's home or physical location must be listed as the billing service location, it must be set up as a service location, with POS 02.

Q: In Kareo, how do we make each Medicare patient's address the service address? Especially since all claims have to go electronically.

A: Fortunately, we received an update that Medicare now wants the provider location listed with POS 02 for their services via telehealth. This should reduce the need for patient home service locations. However, some payers may want the patient's location listed as the billing service location. When that occurs, the patient location will need to be set up as a service location for the practice, likely with POS 02.

Q: Does Kareo offer telehealth services?

A: Yes. Kareo offers HIPAA-compliant video visits that allow providers to connect with patients anytime,anywhere. It's simple, secure and streamlined - and fully reimbursed by private payers. Learn more about Kareo Telehealth here, or chat with a Kareo representative to learn more or to schedule a demo.

Q: Will Kareo Billing (PM) allow us to bill telehealth visits if we are not signed up for Kareo's telehealth services?

A: Yes. You can bill telehealth services without utilizing Kareo's telemedicine system. Kareo Billing utilizes our telemedicine rules engine, ensuring private payer reimbursement for scheduled visits. Learn more about our telemedicine rules engine here.

Q: When will Kareo and the clearinghouse be ready to process claims related to COVID-19?

A: All ICD-10-CM, HCPCS, and CPT codes are loaded in Kareo now. Trizetto has confirmed they are ready to process claims 4/1/20. However, keep in mind that new codes get added frequently due to new vaccine manufacturers so we will adjust as needed.

Q: For Kareo Telehealthservices, do we need to create a telehealth service location with the office address?

A: No, you do not need to create a service location because there is a separate telehealth appointment mode. However, you may want to identify "where" the session is being completed on the provider's side.

Q: What's required of a HIPAA-complaint video platform?

A: The Office of Civil Rights (OCR) has no set guidelines for what constitutes a HIPAA-secure video platform. You can review their website for some suggestions and links to industry

standards. One standard to look for is 256 bit encryption. We recommend Kareo Telehealth, as all video visits are HIPAA-compliant.

Q: Can we use other tools (webex,doxy) and still bill through Kareo?

A: Yes. Whether or not you choose to use Kareo's Telehealth platform, Kareo will always be your billing platform for all your services.

Q: Does Kareo provide a summary of telehealth visits and then upload it into Kareo Clinical after the telehealth call?

A: The provider will want to complete a visit note similar to an in-person visit for documentation purposes. To be HIPAA secure, telehealth systems do not record the visit.

Q: Can we set up telehealth services under our billing company?

A: Your clients will be the ones to make the decision to activate telehealth for their practice. Your billing company plays a critical role in educating clients about the benefits of telehealth and working with your providers to help them activate Kareo's telehealth solution.

Q: How do I edit the messages (email or text) that go out prior to appointments?

A: Appointment reminder email, text and telephone call reminder messages are currently static messages. Telephone call reminders are customizable in that the name of the practice may be recorded.

3.3 Payment & Billing

Q: What is the payment amount for "virtual check-in" G-code?

A: Reimbursement varies payer to payer, including Medicare depending on the geographic location. You should check your payer fee schedules to determine if they are covered, and at what rate.

Q: When billing Medicare for a telehealth service (such as an office visit), what would be the correct modifier that should be used between 95, GT, GQ alongside with POS 02?

A: Medicare does not want any modifier. Using POS 02 denotes telehealth. Using a modifier would duplicate that information.

Q: We are concerned patients are going to refuse to pay, stating that everything related to COVID-19 is 100% covered. How will insurance companies know?

A: For Medicare, that is a correct statement - everything related to COVID-19 is 100% covered. The government has also encouraged commercial payers to do the same. Your practice should be aware of the COVID-19 coverage policies for your major payers and have them ready to discuss with patients. One recommended best practice is to discuss patient financial responsibility prior to the office visit so there are no surprises.

Q: What should we use as the patient location if the patient is in their car? For example, in front of the practice in the parking lot.

A: What a great question! I would use the patient's "home", as their car is personal property. The point is to denote that they are not at a medical facility and less to geo-locate them on a map. We are in uncharted territory and some 80/20 will have to apply. In that event, use a home visit CPT code for the service.

Q: If a payer waives the patient copay or co-insurance, will they pay the provider directly or is it a loss for the provider?

A: A payer will not waive copay or co-insurance. The payer will either cover the full service or allow the provider the option to waive patient responsibility. If the provider chooses to waive patient responsibility, it is a write-off.

Q: How will insurance companies know that patient appointments and/or treatments are for COVID-19 symptoms so the patient doesn't have to pay?

A: Great question. The intent is to cover the care once a diagnosis has been made, so reporting U07.1 or B97.29 would be the trigger for full coverage. At this time, we are unsure if they intend to cover differential diagnosis appointments.

Q: Is Medicare covering telephone visits?

A: Medicare is covering the telephone visit codes during the emergency.

Q: When you say "write-off Medicare", does this mean physicians can charge cash-pay for services?

A: What this means is that you bill Medicare for covered services, but you are also permitted to temporarily not bill the patient for their responsibility if they don't have a secondary payer. You may write it off if you choose to help out patients who cannot afford to pay.

Q: Can you clarify your statement that commercial payers require the POS on a claim to be where the provider is? Does this mean we shouldn't bill POS 02 or POS 11; but instead bill POS 12 if the therapist is at home during the service provision?

A: Commercial payer requirements vary widely on their requirements for telehealth. Often, they will want the provider service location and POS 02, telehealth. If your provider is working from home temporarily, you will likely continue to use the office location and POS 11 or 02.

Please review your major payer telehealth policies and any interim COVID-19 policies for the best information to bill clean claims.

Q: We bill for PT/OT/ST and now those are being allowed sometimes when rendered via telehealth. Is there any direction you can provide for billing commercial insurance plans and determining if/when these plans will cover these services rendered via telehealth?

A: You are correct that some payers are covering these services now. Medicare has expanded their telehealth coverage to include some PT/OT/ST services. Continue to review your major payer websites for telehealth policies and interim COVID-19 policies for the best information.

Q: NY Medicaid covers telephone encounter E&M (CPT code 99441-99443), but Medicare does not cover those codes. How should we bill for dual patients?

A: Medicare is covering the telephone service codes during the emergency period.

3.4 Telehealth

Q: Will Physical and Occupational Therapy be covered for offering telehealth services?

A: Medicare has announced coverage for 97110, 97112, 97116, 97161-97168, 97535, 97750, 97755, 97760, and 97761. Some commercial payers may also provide coverage. Check your major payer websites for coverage updates.

Q: Are most payers waiving HIPAA restrictions and allowing FaceTime or Skype for telehealth if the current EHR is not set up for audio/visual visits?

A: Only CMS has specifically noted this because HIPAA is a federal law, not payer specific. All payers that allow electronic billing are covered entities that fall under HIPAA regulations and

thus, must follow the regulations published by CMS and OCR. The loosened restrictions apply to all telehealth services, regardless of payer.

Q: What are you hearing from payers in regards to their systems being updated to accept telehealth services?

A: Payers already cover telehealth services and can reimburse them at any time, according to their telehealth policies. Check your major payer websites for telehealth updates and interim COVID-19 policies.

Q: Is there any limit for telehealth encounters?

A: Payers may have different policies, so always check your major payer websites for telehealth policies and interim COVID-19 policies. Review the Medicare MLN booklet for Telehealth Services, as Medicare does have some frequency limitations for inpatient and nursing facility services.

Q: Can a scheduled office visit be converted to telehealth phone/video visit?

A: Yes. The schedule does not limit the service type.

Q: Can the provider do Annual Wellness Visits via telemedicine?

A: Please review the Medicare MLN Booklet for Telehealth Services for all covered services. Annual Wellness Visits are a covered telehealth service.

Q: Is there any documentation guideline regarding telehealth visits?

A: Yes, document that it was conducted via telehealth, the patient consented to conducting the visit via telehealth, include names of everyone who was present for the visit, and that the patient consented to them being present. These are the only differences in a telehealth vs. an in-person visit.

Q: For documentation purposes, what is required to bill telehealth? Are all elements still required for both new and established patients?

A: If the service rendered is an Evaluation and Management service, all of the same elements are required for a telehealth visit as an in-person visit. The visit may also be billed based on time if counseling and coordination of care dominate the visit, as with an in-person visit.

Q: Our company bills for non-Medicare services. Since commercial carrier policies are still not completely established regarding telehealth, would it be best to use Mod 95 for CPT(level I) codes and GT for HCPCS (Level II) as a general practice?

A: Having a general practice, or "billing payer blind" is not recommended, as it will cause rejections, delayed reimbursement and more expensive claims. We highly recommend checking your major payer websites for their telehealth policies and any interim COVID-19 policies. We also recommend creating a telehealth billing grid to have handy while billing.

Q: What platforms are acceptable to use for telehealth? Are apps such as FaceTime, Whatsapp and Skype okay to use?

A: The Office of Civil Rights (OCR) has loosened the HIPAA security requirements during the pandemic to allow these more general services to be used for telehealth. However, they do not allow public facing apps such as Facebook Live to be used. We caution you that once the crisis is over, OCR is likely to require HIPAA security requirements to be followed so putting a secure system in place now is best practice.

Q: How do you document a physical exam for new patient visits via telehealth?

A: The provider should document any physical exam elements they are able to complete via telehealth. However, the provider should not document any elements they ask the patients, as those are subjective. If the patient has a system to record vital signs, they may be relayed

and recorded as an element of the exam. Telehealth does restrict the amount of objective exam information that may be collected.

Q: Can providers use telehealth for patients in a different state where they are not licensed?

A: Medicare has stated they will reimburse these services, but we have not heard that any state is loosening medical practice law to allow this. Review state laws and any interim COVID-19 policies for the state in which the patient lives to ensure your provider is adhering with medical practice requirements. Also, it's best practice to ensure your provider's malpractice coverage covers telehealth and working in the patient's state.

Q: Do providers need to credential with payers before providing telemedicine services?

A: Telemedicine services are reimbursed similarly as in-person services. If a provider wants to receive in-network reimbursement rates, they should have a contract and be credentialed with a payer before providing services to their insured parties.

Q: Can you discuss how mental health providers should bill for telehealth?

A: Mental health telehealth is billed similarly to in-person mental health services and other telehealth. Modifiers are necessary only if the payer requires a modifier to denote telehealth.

Q: Do you have guidelines as to what CPT codes are allowed for physical therapists to use for billing commercial payers for telehealth services?

A: This will vary based on the payer's PT telehealth coverage. Review the telehealth and interim COVID-19 policies for your major payers to determine if they are covering PT via telehealth and what services/codes are covered.

Q: Do the Medicare billing rules apply to all Medicare advantage plans in regards to telehealth?

A: Generally, Med Advantage plans must cover telehealth. Beyond that, they tend to follow the commercial payer rules such as whether they require a telehealth modifier or what POS to use. Consider them part of the commercial payer when reviewing billing rules.

Q: What is the difference between telemedicine and online services? Can you give examples of when to use each?

A: The telemedicine services that we have been discussing are performed during a live video conference between the provider and the patient. Online services are conducted via secure email, a secure patient portal, or other secure communication system such as a texting or chat app.

3.5 Modifiers

Q: What are the modifiers for telehealth by phone?

A: There are no modifiers for this. This is a telephone service, rather than telehealth by phone. Telehealth includes a live audio and video service.

Q: When billing for psychiatrists, you need the E&M code plus the add-on psychotherapy code. Do you put a modifier on the 99212 (E&M) or 90836 (add-on psychotherapy). What is the modifier?

A: Only report both an E&M code and an add-on psychotherapy code if both E&M services and psychotherapy of sufficient length are provided. If the payer requires a modifier to report

telehealth, their policy will also note whether the modifier should be placed on only the primary code or all codes.

Q: What is Modifier 95 and when do we use it?

A: Modifier 95 is a level I CPT modifier denoting telehealth services. It sends the same information to the payer as POS 02. Some payers may want it used to report telehealth services. You'll want to review the telehealth policies of your major payers to see if they want this modifier used.

Q: What's the difference between 95 and GT modifiers?

A: Nothing. They both report synchronous telehealth services. GT is a level II HCPCS modifier created by CMS before CPT created 95. Medicare no longer accepts GT but has not deleted the modifier in the event other payers may use it.

Q: When should we use a modifier?

A: Only when the payer directs you to.

Q: What are the category II modifiers used for?

A: Category II modifiers are used for a variety of information. They are created by CMS and listed with HCPCS. Category I modifiers are created by CPT and listed in the CPT manual. Category II modifiers can be informational, allow payment, or affect payment, just like Category I modifiers.

Q: Do you have to have category 1 and category 2 modifiers when you submit telehealth claims?

A: No. Category I and Category II modifiers are just created by different organizations. If a payer wants a modifier, you would use one or the other, not both.

Q: If providers are at home seeing a patient via telehealth, do we need to use a POS 02 with a telehealth modifier?

A: That depends on each payer's policy. Review your major payer's policies on their websites for more information. You will likely never use POS 02 and a telehealth modifier at the same time because they give the payer the same information.

Q: Do you know if commercial insurances are requiring modifier codes for Behavioral Health telehealth visits?

A: There are no known special modifiers required for Behavioral Health telehealth.

Q: Does the telehealth modifier go before other modifiers that we normally use, or after?

A: If the payer requires a telehealth modifier, use the usual modifier rules - place modifiers affecting payment first, then informational modifiers.

3.6 Other

Q: What does MAC stand for? Can you give an example?

A: A MAC is a Medicare Administrative Contractor. They administer the Medicare program in different regions of the country. Noridian is a MAC.

Q: What's the process to apply for MAC?

A: A MAC is not applied for. A practice enrolls with a MAC in order to be reimbursed for services. They enroll service locations and providers. Right now, watch the MAC website for your region for the enrollment hotline number to be listed.

Q: With COVID-19, CMS regulations will require synchronous only, not asynchronous?

A: No changes have been made to asynchronous coverage at this time. Continue to check your major payer websites for interim COVID-19 policy changes.

Q: Can you go into some depth about mental health billing?

A: There aren't any special rules regarding mental health billing via telehealth. Read the Medicare MLN booklet for Telehealth Services for covered services. Check your major payer websites for telehealth policies and interim COVID-19 policies.

Q: Are there any international restrictions?

A: Medicare does not provide coverage for services when the provider or patient is located outside of the U.S. You should check your major payers for similar policies.

Q: Can telephone services be initiated by a provider?

A: CPT states they must be patient initiated.

Q: What is the anti-kickback statute that has been waived?

A: The anti-kickback statute is a Stark law that states a provider cannot induce patients to their practice by providing patient discounts. The Stark laws by and large have been suspended to allow flexibility in hiring and mobility of the healthcare workforce and movement of healthcare equipment, including telehealth equipment.

Q: When documenting encounters for telehealth "video", do we document the patient's address and/or only location "home"?

A: Patient home is fine in the note.

Q: What if a patient is not diagnosed with COVID-19? For example, if the patient has a cough and cold, do we still have to waive cost share?

A: The practice does not HAVE to waive the cost share. At this point, the patient is not diagnosed, thus this is not a COVID-19 service. When it is a COVID-19 service, Medicare will cover the entire cost of care. The practice will not lose the cost share. For the symptoms service, the practice has the option to waive the cost share if they choose to do so to support patients in need.

Q: What is Category I?

A: This could apply to CPT codes and modifiers. Category II is what we usually call HCPCS codes and modifiers. CPT is technically HCPCS Level I and what we call HCPCS is HCPCS Level II.

Q: What does RHC and FQHC mean?

A: RHC is a Rural Health Clinic andFQHC is a Federally Qualified Healthcare Clinic. They service rural and urban populations and receive special funds to do so.

Q: If the provider is going to a patient's car to test, is that a POS 11?

A: If it is in your practice parking lot, the answer is yes.

Q: Can you please explain in more detail about Sequestration for 2020?

A: It looks like Sequestration will no longer occur for the rest of 2020, effectively giving all providers a 1.6% increase for the year. This is a Medicare budget process that has been in place for some years where 1.6% of all services have been retained by Medicare.

Q: Can providers work from their home vs. a clinic site? If yes to home, what modifier and place of service?

A: Yes. If it is temporary, keep reporting the office location. If it is going to be more long term, you may want to enroll your home office as a location with payers. You will likely report a modifier OR a special POS to denote telehealth. Check your major payers for their policies to ensure clean claims.

Q: Has the CMS definition of homebound status changed? Can I initiate a telehealth visit with a new Medicare patient who can drive but is "homebound" during this emergency?

A: Medicare is encouraging all beneficiaries to remain at home and travel as little as possible during the crisis, so the definition of homebound does not apply to this situation. New patient visits may be initiated via telehealth during the emergency.

Q: Are all of these codes/services including services provided by a registered nurse?

A: None of these codes/services are provided by a registered nurse. Review the Medicare MLN booklet for Telehealth Services for the providers that may provide telehealth services. There are other services non-independent providers may provide via telephone. Commercial payers may have policies that allow nurses to provide certain telehealth services. Review those policies on their websites.

Q: If a patient has seen their PCP via telehealth within the last seven days, can a mental health provider see the same patient and bill for telehealth services?
Or, is this saying that a patient cannot be seen by the same provider for the same services within seven days via telehealth?

A: A patient cannot receive the same services by the same provider via telehealth within seven days.

Q: If a practice and provider are already enrolled with Medicare but have never provided telehealth services, does this mean we have to submit a different/new enrollment with CMS in order for those services to be reimbursed?

A: No additional enrollment is necessary.

Q: I operate a virtual healthcare clinic that treats patients with chronic conditions 100% via telehealth. We're moving into working with Medicare patients, but I'm confused as to how to establish a new patient if we're operating 100% in telemedicine.

A: You are currently able to do that via telehealth during the emergency.

Section 4: Conclusion

Feeling overwhelmed with your billing? Kareo can help match you with a trusted independent billing company that knows the industry and will help you navigate the current climate. Visit https://www.kareo.com/medical-billing to learn more.

About Kareo

Kareo is the leading cloud-based complete medical technology platform purpose-built to meet the unique needs of independent practices and their billing partners. Today we help over 75,000 providers and 1,600 billing companies across all 50 states run a more efficient and profitable business, while setting them up to deliver outstanding patient care. With offices across the country, our mission is to help independent practices–and the billing companies that support them–succeed in an ever changing healthcare market. For more information, visit Kareo.com or for more COVID-19 related information, visit us at Kareo.com/covid-19.