

# CORONAVIRUS DISEASE 2019 (COVID-19)

## Revenue Excellence Telehealth FAQs



**Audience:** Acute & MPGS Patient Access/Registration, CBO, Revenue Integrity and Coding Teams, MGPS Provider Services, Clinically Integrated Network, Ambulatory Care Management

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**If your question is not addressed below, please send an email to Bill Lucyshyn  
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### **New Questions 4/28**

#### **“CS” Modifier Usage**

**Q:** Would the “CS” modifier be added to an E/M if the patient was being evaluated for the purposes of determining the need for a test, and is determined not to need the test.

**A:** No, Per the MLN article and questions that CMS has answered during their COVID-19 calls, we would not append the “CS” modifier to the E/M for a visit that rules out the need for COVID testing. CMS has repeatedly stated that the “CS” modifier is used for visits that result in an order for COVID testing or include the COVID test.

**Q:** Should the “CS” modifier be appended to an E/M, if a patient who is a known COVID positive (from a previous test either at our hospital, in the community or elsewhere) presents to our hospital for an emergency room or office visit for evaluation of continued symptoms related to COVID and assigned a diagnosis of U07.1, but a COVID test was NOT ordered as a result of the visit?

**A:** Modifier “CS” would not be assigned to the E/M on this account. The “CS” modifier is used for visits that result in an order for COVID testing or include the COVID test. If CMS expands use of the “CS” modifier or expands waiver of beneficiary cost-sharing further, we will share that through additional communications.

### **Previous Questions & Answers**

#### **FQHC/RHC Billing**

**Q:** On March 30, 2020, CMS through the Interim Final Rule published guidance and updates for telemedicine services allowed in an FQHC/RHC. What services can be provided virtually to patients in an FQHC/RHC?

**A:** The below listed services are now able to be billed under HCPCS code **G0071** Payment for communication technology-based services for 5 minutes or more of a virtual (non-face-to-face) communication between an RHC or FQHC practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only.

- **G2012 (Virtual Check-in)**
- **G2010 (Remote eval recorded video/images)**

- **99421 – 99423 (Online/E-visits)**
  - **Added as a result of COVID-19, effective 3/1/20**

The RHC and FQHC face-to-face requirements are being waived for these services. Section 405.2464(e) establishes payment for communication technology-based and remote evaluation services, and no regulatory changes are required.

On April 17, CMS published the promised additional guidance from the CARES act. The following document has been published to the Trinity Health COVID-19 Intranet page:

1. Go to <http://www.trinity-health.org/covid19-resources>
2. Scroll down to the “Resources by Department” section
3. Click on “Revenue Excellence & Finance” header
4. Find the “COVID-19 SE20016 RHC and FQHC Guidance” document

### **Telehealth visit technology failure**

**Q:** How should a provider bill a telehealth (audio and visual, two-way technology) visit if the technology fails?

**A:** Current instruction is to bill utilizing the medium used for the majority of the visit. For example, if 5 minutes was audio/video and 15 minutes phone, it is recommended to bill for a phone visit for the 20 minutes. Assigning a code for a visit is not based upon "intent".

### **Telehealth for Mental Health Visits**

**Q:** What are the current guidelines around providing Psychology & Psychiatry services via telehealth services?

**A:** Please refer to the guidance included in the summary of the Interim Final Rule for CMS specific information, found at the following location:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section
- Scroll to the “Revenue Excellence” section
- Find the “COVID Interim Final Rule 2020” document

Please refer to your local state Medicaid and payers for specific information around the services that they allow via Telehealth.

### **CR Modifier Usage**

**Q:** Is there any guidance regarding the usage of the “CR” modifier on professional claims?

**A:** Modifier CR is "catastrophe/disaster related", at first when the waivers were published there was instruction to use modifier CR although the "interim final rule" stated that Medicare is not requiring modifier CR. Some carriers are requiring modifier 95 to indicate "telehealth" and modifier "CR" to indicate that the service is COVID-19 related. The requirements are very payer specific.

For further guidance on the Interim Final Rule, please refer to the document posted to the Trinity Health COVID-19 Intranet page:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section

- Scroll to the “Revenue Excellence” section
- Find the “COVID Interim Final Rule 2020” document

### **Telehealth Resident Billing in a Primary Care Exception Clinic**

**Q:** Is it appropriate to use the “GE” modifier when billing for services rendered, in a Primary Care Exception Clinic, by a Resident and the Teaching Physician is “present” via Telehealth?

**A:** Yes, the GE modifier is appropriate to append to the E & M code in the Primary Care Exception Clinic setting. With the primary exception you must "review care furnished by residents during, or immediately after, each visit. This must include a review of the patient’s medical history and diagnosis, the resident's findings on physician examination, and the treatment plan (for example, record of test and therapies)." That care must be provided jointly with the resident and teaching physician. Since they are not together then YES, using audio **and** video, the teaching provider can be involved.

The teaching physician’s supervision requirements during a telemedicine visit include "audio & visual technology" during the key components of the exam. The teaching physician determines the key components.

The duration of the visit is the total documented time spent with the patient.

Please review the following for further information: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf>

### **Provider Documentation**

**Q:** Are there any documentation requirements by the hospital staff or is the documentation by the provider who is making the call (indicating what was provided and how rendered) enough to justify the hospital billing?

**A:** Time and method of interaction is the most important piece of the documentation...everything else is to the best of your ability to do the required assessment...Here are bullets to follow:

- Documentation requirements for a telehealth service are the same as for a face-to-face encounter.
- The information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented.
- Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.
- Like an office visit, it is important to focus on the chief complaint.
- Remember to check CURES for drug seeking patients. Currently, DEA-registered practitioners can issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation.
- Be sure to check if anything has changed in their medical or surgical history. Remember, you won’t have an MA to help you.
- Try to complete your note and refill or prescribe medication immediately after the visit has ended.
- Be sure to document how much time you spent with your patients.

## Telehealth

**Q:** Can telehealth be provided using EITHER telephone (audio only interaction with patient) or video (audio and visual interaction with patient)?

**A:** **NO, Telehealth must be a Synchronous interaction with the patient via VIDEO & AUDIO**...If you are only interacting with the patient via a Telephone call...then your codes are limited:

Telephone only			
Commercial			wRVU
99441	5-10 min, <b>Physician or APP</b>	\$14.44	0.25
99442	11-20 min, <b>Physician or APP</b>	\$28.15	0.5
99443	21-30 min, <b>Physician or APP</b>	\$41.14	0.75
98966	5-10 min, <b>Clinical Staff</b>		
98967	11-20 min, <b>Clinical Staff</b>		
98968	21-30 min, <b>Clinical Staff</b>		
No Modifier needed			

## “Incident to” Visits

**Q:** Has there been any published guidance that would change “incident to” billing practices when utilizing Telehealth?

**A:** No, The current guidance is that the visit must meet the same criteria as prior to COVID-19. No relaxation of requirements to “incident to” have been published at this time.

## Provider Enrollment

**Q:** Do providers need to update their enrollment with CMS in order to provide and bill for telehealth services they provide from their home?

**A:** No, As of 3/31 CMS has posted guidance that states the following, “Postpone all revalidation actions. Allow licensed providers to render services outside of their state of enrollment. Expedite any pending or new applications from providers. Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.”

<https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf>

## Telehealth Services

**Q:** What services can be provided via telehealth now?

**A:** On Monday 3/30, CMS released an expanded list of services that can be provided by MD's, DO's, & APP's via Telehealth (2-way Real-Time Audio/Visual Communication).

<https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

The below services are now available for MEDICARE (**please consult your local payer rules to verify their list**) patients via Telehealth, if the provider is credentialed to provide the below services:

- Emergency Department Visits, Levels 1-5 (CPT Codes 99281-99285)

- Initial & Subsequent Observation and Observation Discharge Day Mgmt (CPT Codes 99217-99220; CPT Codes 99224-99226; CPT Codes 99234-99236)
- Initial hospital care and hospital discharge day mgmt (CPT Codes 99221-99223; CPT Codes 99238-99239)
- Initial skilled nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT Codes 99304-99306; CPT Codes 99315-99316)
- Critical Care Services (CPT Codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT Codes 99327-99328; CPT Codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT Codes 99341-99345; CPT Codes 99347-99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT Codes 99468-99473; CPT Codes 99475-99476)
- Initial and Continuing Intensive Care Services (CPT Codes 99477-99480)
- Care Planning for Patients with Cognitive Impairment (CPT Code 99483)
- Psychological and Neuropsychological Testing (CPT Codes 96130-96133 ; CPT Codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT Codes 97161-97168; CPT Codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97661, 92521-92524, 92507)
- Radiation Treatment Management Services (CPT Code 77427)

A full list of Medicare approved codes has also been posted to the Trinity Health COVID-19 Intranet page:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section
- Scroll to the “Revenue Excellence” section
- Find the “Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020” document

Per the [Interim Final Rule](#) that has been posted, “To implement this change on an interim basis, we are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.”

For further guidance on the Interim Final Rule, please refer to the document posted to the Trinity Health COVID-19 Intranet page:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section
- Scroll to the “Revenue Excellence” section
- Find the “COVID Interim Final Rule 2020” document

### **Critical Access Hospitals & Method II Billing**

**Q:** For Critical Access (CAH) and Method II billing of Medicare pro-fees on the UB-04 claim, do we still apply the GT modifier?

**A:** Per MLN SE20011, when a telehealth service is billed under CAH Method II, the GT modifier IS required.

## Provider Based Billing (Split Billing)

**Q:** Can we split telehealth services into a professional and technical claim?

**A:** Yes, however all “Technical” (UB) claims need to be held at this time. On Monday (3/30), Medicare released (see link below) new guidance on how to bill Telehealth services (Addressed above). We are currently interpreting this guidance to mean that we should continue to bill as we have in the past, creating a “Professional” and “Technical” claim, including the “95” modifier on the 1500 to notate that the service was rendered via Telehealth. The issue that is not resolved by the CMS guidance, at this time, is whether they will be reimbursing for the “Technical” portion of the visit. We will continue to monitor guidance released by CMS and provide guidance on the final determination for the UB claims, which would require a “DR” condition code, in a future FAQ update.

<https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>

## Medicare Annual Wellness Visits

**Q:** Can providers utilize Telephone only telehealth visits to bill for Medicare Annual Wellness Visits?

**A:** No, While an Annual Wellness Visit is approved as a telehealth service, the mode of service does not include just a Telephone connection, the guidance at this time is that two-way communication utilizing audio and video is the only way to bill for an AWV. Annual Wellness Visit as an e-visit is **not approved**. For further details, please refer to the CMS telehealth services booklet: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>

## Nutritionists that already bill on a 1500

**Q:** How should Nutritionists who currently bill the following codes, 97802 (Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes) and 97803 (the re-assessment), on a 1500 bill for their services with a Place of Service of “Telehealth” (02)?

**A:** At this time, the guidance is that Nutritionists should continue to utilize these same codes and bill with a Place of Service “Telehealth” (02). You may utilize one of these modifiers as well *depending on the payer* and mode of interaction with the patient:

- GQ - Telehealth service rendered via asynchronous telecommunications system
- GT - Via interactive audio and video telecommunication systems
- 95 - Synchronous Telehealth Service Rendered via Real-Time Interactive Audio and Video Telecommunications System

For further guidance please refer to the document posted to the Trinity Health COVID-19 Intranet page:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section
- Scroll to the “Revenue Excellence” section
- Find the “COVID Interim Final Rule 2020” document

## Telehealth Facility Billing & Coding Guidance

**Q:** What is the current guidance for how hospital-based services (Physical Therapy, Occupational Therapy, Speech Therapy, Cardiovascular rehab, etc.) should bill for Telehealth Services?

**A:** The Revenue Excellence team has created a document that is posted to the Trinity Health COVID-19 Intranet page:

- Go to the following link: <http://www.trinity-health.org/covid19-pulse>
- Click on the “Department” section
- Scroll to the “Revenue Excellence” section
- Find the “COVID-19 Telehealth.Telemedicine Visits Technical and Professional Billing” document

### **The Coronavirus Aid, Relief, and Economic Security Act (S. 3548) of 2020 (CARES)**

**Q:** What are the current known highlights from the CARES Act.

**A:** The following are known pieces of the legislation related to telehealth:

Section	Provision Title	Brief Description
Section 3701	Exemption for telehealth services	Allows a high-deductible health plan (HDHP) with a health savings account (HSA) to cover telehealth services prior to a patient reaching the deductible.
Section 3703	Increasing Medicare telehealth flexibilities during emergency period	Eliminates the requirement in the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 that limits the COVID-19 Medicare telehealth expansion authority during the COVID-19 emergency to situations where the physician or other professional has treated the patient in the past three years.
Section 3704	Enhancing Medicare telehealth services for Federally qualified health centers and rural health clinics during emergency period	Allows Federally Qualified Health Centers and Rural Health Clinics to furnish telehealth services to Medicare beneficiaries in their home or other setting during the public health emergency. Medicare would reimburse for these services at a composite rate similar to payment provided for comparable telehealth services under the Medicare Physician Fee Schedule.