Medicare Telehealth Services: Existing Policy vs. COVID-19 Policy

On March 30, 2020, CMS released a new round of updates on the use of Telehealth during the COVID-19 National Public Health Emergency (PHE). Effective March 1, 2020 and for the duration of the PHE, Medicare will make payment for Telehealth services. The chart below highlights the differences and similarities between existing and temporary COVID-19 Telehealth rules. These temporary rules will expire when the Secretary of HHS declares the end of the public health emergency. The following information, developed by the American Society of Clinical Oncology (ASCO) for its members, is in reference to a specific list of Medicare Telehealth Services; for information on Telephone E&M, E-visits and remote check-ins, please see page 2.

	Policy Prior to COVID-19 Emergency	Temporary Change During COVID-19 Public Health Emergency
What services are eligible for telehealth?	Refer to Medicare's List of Telehealth Services. Examples include office visits (99201-99215), advance care planning (99497, 99498), and annual wellness visits (G0428, G0439)	The list of services has been expanded to home visits, inpatient visits, radiation treatment management, telephone E&M and others. See Medicare Telehealth Services for the complete list of eligible services.
Which patients are eligible?	Some services require an established relationship between the patient and provider	New or established patients; not limited to patients with or suspected of having COVID-19; HHS will not audit for prior patient/physician relationship
What are the geographic restrictions?	Patient must live in a rural area	All Medicare beneficiaries are eligible regardless of where they live
Where can the patient be located?	Patient must receive services at physician office or other qualifying facility (originating site)	May receive services at home or in a facility; originating site requirements are waived
How are levels of service selected?	In 2020, level of service is based on 3 components: history, exam and medical decision-making.	The level of service may be selected based on medical decision-making or total time spent on the E&M service. A medically appropriate history and patient-assisted examination should be performed
What is the cost sharing for the patient?	Beneficiary cost sharing applies	The HHS Office of the Inspector General (OIG) provides physicians the flexibility to waive or reduce cost-sharing for telehealth services; OIG will not subject physicians and other practitioners to OIG administrative sanctions when cost-sharing is reduced or waived. An OIG policy statement with further details is available here
Which communication platforms can be used for telehealth visits?	Must be real-time audio-visual communication through a HIPAA approved communication platform with vendors that will enter into HIPAA business associate agreements	Must be a real-time, audio-visual communication platform, with one exception. Telephone E&M visits, codes 99441-99443, may be audio only HIPAA requirements are waived temporarily; however, communication must NOT be public facing. Examples of what currently is and is not allowed below: Allowed Platforms: • Apple FaceTime • Facebook Messenger Video Chat • Google Hangouts Video • Skype Not Allowed: • Facebook Live • Twitch • TikTok
What is the payment for telehealth visits?	During the public health emergency, providers are instructed to bill Medicare based on their typical place of service, i.e. where the service would have been otherwise performed (office, outpatient hospital). The resulting payment will be equal to what you would have otherwise been paid	
How do I report these visits?	Place of service code: **(during the public health emergency, bill using your typical place of service code, with modifier 95 to signify a telehealth service)** Other Modifiers: GQ for services through an asynchronous telecommunications system	
Who is a Qualified Provider for this service?	Physicians, nurse practitioners, physician assistants, certified nurse midwives, certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals, physical therapists, occupational therapists, and speech language pathologists within their scope of practice and consistent with Medicare benefit rules that apply to all services	

Answers given within this document are based on Medicare & Medicaid rule CMS-1744-IFC, and were last updated on March 30, 2020. Coronavirus Waivers & Flexibilities, and the HHS Telehealth website and were last updated on April 23, 2020. Medicare and Medicaid rule CMS-55341 and were updated on April 30, 2020.

Other Electronic Services Allowed by Medicare

In recent years, Medicare has expanded the scope of electronic services eligible for reimbursement. Note that these services differ from "Telehealth Services" in how they are billed and paid by Medicare. Please refer to the following FAQs for Medicare beneficiaries. Check with your Medicaid, Medicare Advantage, and commercial plans for their billing requirements.

Virtual Check-ins

What services are paid for as Virtual Check-ins?

- G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified HCP who can report E&M, provided to a patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- G2010: Remote evaluation of recorded video and/or images submitted by a patient (e.g. store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E&M service provide within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment

How are virtual check-ins different from telehealth visits?

- Virtual check-ins are brief services that may not necessarily qualify for an E&M visit code
- Virtual check-ins do not require real-time, audio-visual communication, but include a broader range of methods, such as telephone
- NEW: Virtual check-ins may now be billed for new patients during the public health emergency

How do I report virtual check-ins?

- Virtual check-ins are billed with G2012 (real-time) or G2010 (store and forward, with follow-up)
- Virtual check-ins are billed based on the location from which the provider is located (e.g. 11-office) and do not include the telehealth modifier
- Verbal consent from the patient must be obtained and documented for billing

E-Visits

What services are paid for as E-Visits?

- 99421: Online digital evaluation and management service, for a patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: 11– 20 minutes
- 99423: 21 or more minutes

What if the provider is not a physician, NP, PA, or CNS (e.g. physical therapist, clinical psychologist)?

- G2061-G2063 is billed in place of 99421-99423

How are E-visits different from telehealth visits?

- E-visits must be initiated by the patient
- E-visits may be performed through patient portals, secure e-mail, telephone, and/or other digital applications
- E-visits are billed based on the length of the service within 7 days

How do I report E-visits?

- E-visits are billed based on the location from which the provider is located (e.g. 11-office) and do not include the telehealth modifier
- Verbal consent from the patient must be obtained and documented for billing

Telephone Evaluation & Management Services

What services are paid for as telephone calls during the public health emergency?

- 99441: Telephone E&M service by a physician or other qualified HCP who may report E&M services provided to an ~~established~~ patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442: 11-20 minutes of medical discussion
- 99443: 21-30 minutes of medical discussion)

What is the reimbursement for these calls?

- *Reimbursement for these calls are equivalent to an established in-person visit code (99212-99214).*
- *Reimbursement range is approximately $46-$110*

What patients qualify for telephone E&M services?

- During the public health emergency, telephone call services may be provided to new or established patients
- Patients do not require video capabilities; audio-only community qualifies as a telephone E&M service

What if the provider is not a physician, NP, PA, or CNS (e.g. physical therapist, clinical psychologist)?

- 98966-98968 is billed in place of 99441-99443