COVID-19 Telehealth and Payer Guidance

Information is accurate as of 4/1/20

If you have any questions about the information below, please contact us at advisoryservices@mckesson.com.

Available Medicare Telehealth Services

Telehealth Visits:

- Code range 99201 – 99215
  - Requires real-time audio *and* visual communication between patient and provider (e.g. Facetime, VSee)
- Telephone encounters can be billed based on time using 99441-99443
- New and Established patient visits
- Scheduled by provider to substitute for in-office visits
- Paid at same rate as in-person office visits
- No longer limited to patients within Health Provider Shortage Area (rural areas)
- Use Place-of-Service code 11 with modifier 95 for Medicare claims (Medicare stopped the use of GT Modifier in 2018; check with your private payers on POS and Modifier guidance)
- Must document encounter and patient consent; coinsurance and/or deductible may apply

Virtual 'Check-in' Visits:

- Codes G2010 and G2012 are available and unchanged since 1/1/19
  - G2012- 5-10 minutes of real-time discussion between patient and provider over the telephone
  - G2010- Video/image submission reviewed by provider
  - Under 5 minutes unbillable
- New and Established patients eligible
- Encounter must be initiated by patient
- Typically used to determine if office visit is needed
- Patient complaint must be unrelated to any encounter within last 7 days
- Not separately billable if check-in results in a follow-up appointment
- Must document encounter and patient consent; coinsurance and/or deductible may apply

E-visits:

- Codes 99421 – 99423 for MD/DO/APP use
- New and Established patients eligible
- Encounter must be initiated by patient
- Communication with provider through online patient portal or secure email exchange
- Time-based, using cumulative time spent in email exchanges over 7-day period
- Must document encounter and patient consent; coinsurance and/or deductible may apply

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Telehealth Payer Policy FAQ

How are payers updating coverage policies related to telehealth services?
On March 6, 2020, the President signed into law The Coronavirus Preparedness and Response Supplemental Appropriations Act. This allows the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) period. On March 17, 2020, the Trump Administration announced expanded Medicare telehealth coverage.

Limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. Patients outside of rural areas and patients in their homes will be eligible for telehealth services, effective March 6, 2020. Beneficiaries will not have to travel to their healthcare facility.

Beginning March 6, 2020, CMS will temporarily pay clinicians to provide telehealth services. CMS maintains a list of in-person services that may be furnished via Medicare telehealth. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Again, these services may be provided to patients regardless of patient location.

In addition, effective immediately, the HHS Office for Civil Rights (OCR) stated that it will "exercise its enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies," including Apple FaceTime, Facebook Messenger or Skype, during the COVID-19 nationwide public health emergency.

Commercial payers are changing their telehealth service policies from non-covered to covered; however, some payers are appending an end date to the policy. Practices should access private payer websites for the latest updates.

Are private payers waiving co-pay/co-insurance/deductibles for the COVID-19 diagnostic tests?
Yes, some payers are waiving patient responsibility for COVID-19 testing. Additionally, certain payers are also waiving cost share for visits related to treatment. Keep in mind, self-funded employer sponsored plans are regulated by federal law, those plans can opt out of the agreements around copayments for COVID-testing and treatment. Payers continue to make changes to their plan policies, and many are also temporarily waiving patient cost-share for in-network telehealth/telemedicine visits *unrelated* to COVID-19, as well. Please visit payer websites for the most current information.

Will private payers waive prior authorization on COVID-19 related testing or treatment?
According to AHIP, treatment of COVID-19 is being addressed in accordance with the terms of an individual's insurance plan as other viral respiratory infections. However, health insurance providers have emergency plans for global pandemics that allow for the modification of their practices. Any modifications are carefully implemented to balance access to care with ensuring patient safety and evidence-based medicine. Health insurance providers are carefully monitoring COVID-19 developments and will make necessary modifications accordingly.

Resources:

- https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf
- https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit
- https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes