Telehealth: The New Normal

Healthcare Helpings
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Speaker introduction

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Telehealth Basics

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Is there a difference between telehealth and telemedicine?

- CMS's fact sheet states, "Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health."
- There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summarized in the CMS fact sheet: Medicare telehealth visits, virtual check-ins, and e-visits.

Is there a difference between telehealth and telemedicine?

- The World Health Organization (WHO) uses the terms interchangeably. "Some distinguish telemedicine from telehealth with the former restricted to service delivery by physicians only, and the latter signifying services provided by health professionals in general, including nurses, pharmacists, and others."
- CMS has used the terms telehealth and telemedicine interchangeably, creating some confusion in the recently released telehealth changes. It's recommended that providers contact their MAC for verification on questions.

Telemedicine basics

Source: americantelemedicine.org

Type of telemedicine	Definition	Example
Live videoconferencing (synchronous services happening at same time between patient and provider)	The delivery of a live, interactive consultation between primary care and specialist health services. This may involve a primary care or allied health professional providing a consultation with a patient, or a specialist assisting the primary care physician in rendering a diagnosis.	A practitioner virtually consults a patient via two-way video chat platform
Store and forward (asynchronous services NOT happening at same time between patient and provider)	The use of store and forward transmission of diagnostic images, vital signs and/or video clips along with patient data for later review that enables a primary care or allied health professional providing a consultation the ability to render a diagnosis.	Practitioners sending X-rays, MRIs, digital photos of skin conditions, etc., to specialist for review
Remote patient monitoring (RPM)	Including home telehealth, uses devices to remotely collect and send data to a home health agency or a remote diagnostic testing facility (RDTF) for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG or a variety of indicators for homebound consumers. Such services can be used to supplement the use of visiting nurses.	Wifi or Bluetooth-enabled wearables that may report patient activity or heart rate
Mobile health (mHealth)	Consumer medical and health information includes the use of the internet and wireless devices for consumers to obtain specialized health information and online discussion groups to provide peer-to-peer support.	Patient receives text message reminders to take their medication

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Summary of telemedicine services

Type of service	What is the service?	HCPCS/CPT Code	Patient relationship with provider
Medicare telehealth visits	A visit with a provider that uses telecommunication systems between a provider and a patient	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNF) For complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients * To the extent the 1135 waiver requires an established relationship. HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Source: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Summary of telemedicine services

Type of service	What is the service?	HCPCS/CPT code	Patient relationship with provider
Virtual Check-In	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient .	• HCPCS code G2012 • HCPCS code G2010	For established patients
E-Visits	A communication between a patient and their provider through an online patient portal	• 99421, 99422, 99423 • G2061, G2062, G2063	For established patients

Source: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telehealth place of service

Place of service code	Place of service name	Place of service description
02	Telehealth	The location where health services and health-related services are provided or received through a telecommunication system.

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Originating site and distant site

- The originating site is where the member is located at the time healthcare services are delivered to patient by means of telehealth.
- The distant site is any secure location within the United States or US territories where the telehealth provider is located while delivering healthcare services by means of telehealth.

Distant site providers

Source: Medicare MLN Booklet

Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) are:

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs)
- CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional

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Coronavirus Preparedness and Response Supplemental Appropriations Act

In response to coronavirus, the House and Senate passed and the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act. This act became effective on March 6, 2020.

The CPRSA Act allows Medicare to waive certain telehealth restrictions. The waiver of the restrictions are being done under a "temporary and emergency basis" for the duration of the COVID-19 public health emergency.

CMS's expansion of telehealth services are for all Medicare beneficiaries, not just those that have coronavirus.

Medicare 1135 waiver

Changes that took effect March 6, 2020:

- The designated rural area and originating site restrictions have been lifted. This allows qualified healthcare professionals to bill telehealth encounters for any patient in any location.
- During this public health emergency, a waiver is in place that eliminates the need to be an established patient for claims submitted during this period.
- Certain smartphones may be used by provider and patient for telehealth purposes. However, both phones must have audio and video capabilities that allow a real two-way encounter.
- Practices may reduce or waive patient co-pays for telehealth visits.

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Telehealth-allowed diagnoses

Effective March 6, 2020, CMS approved the following:

- Telehealth provision allows care without regard to the diagnosis of the patient to prevent vulnerable beneficiaries from unnecessarily entering a healthcare facility when needs can be met remotely
- Example cited: patient needing a visit with physician for refill of medication
- Services must still be reasonable and necessary

Health Insurance Portability and Accountability Act (HIPAA)

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Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.

For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

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CMS News: March 30, 2020

Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge

At President Trump's direction, the Centers for Medicare & Medicaid Services is taking historic and unprecedented steps to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic.

CMS is issuing a sweeping array of new rules and waivers of federal requirements to ensure that local hospitals and health systems have the capacity to absorb and effectively manage potential surges of COVID-19 patients. The actions announced today introduce flexibilities to permit hospitals and healthcare systems to act as coordinators of healthcare delivery in their areas.

The complete CMS press release can be found at:

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

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Medicare telehealth changes (effective March 30, 2020)

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- Additional hospital services, home visits, and domiciliary services have been added to the CMS list of services that can be provided via telehealth
- Pediatric critical care and intensive care and inpatient neonatal codes may be performed via telehealth
- Temporary additions for additional services that can be performed via telehealth include care planning for patients with cognitive impairment, psychological and neuropsychological testing, physical therapy, and occupational therapy
- Telehealth services can be provided to new or established patient visits ⟵ **Changed 3/6/2020**
- Subsequent inpatient telehealth may be performed daily, without the prior limit of once every three days

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Medicare telehealth changes (effective March 30, 2020)

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Virtual check-ins and e-visits

- Additionally, clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966 - 98968; 99441-99443)

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Virtual check-ins

The two main categories of virtual visits are:

- **Face-to-face video visits**: There are traditionally identified by Medicare as telehealth.
- **Non-face-to-face e-visits and other digital communication**: These are considered "non-telehealth" visits and don't require real-time audio and video interaction. This category includes online evaluation and management (E/M) visits; brief virtual check-ins (by telephone or other telecommunication device); and telephone E/M visits (which payers have traditionally resisted reimbursing but in some cases are now allowing during this public health emergency). For physicians who are treating most patients remotely for the first time, it can be difficult to determine what type of services are being provided, and how to bill for them.

Virtual check-in CPT codes

HCPCS G2010: Remote evaluation of recorded video and/or images submitted by an established 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 provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment—(Store and Forward)

HCPS G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified healthcare professional who can report evaluation and management services, provided to an established 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.

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Virtual check-in guidelines

- Established patients only. CPT defines an established patient as one who has received professional services from the physician or qualified healthcare professional or another physician or qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past 3 years. ***** This has been waived during the COVID 19 pandemic. OK to see new patients**
- Patient-initiated. The physician or provider may respond to the patient's concern by telephone, audio/video, secure text messaging, email, or electronic health record portal.
- Physician **MUST** document patient verbal consent. This is not a blanket consent. Must be done each time this type of service is requested.
- Virtual check-ins can be delivered only by those practitioners authorized to furnish E/M services. Only physicians and qualified healthcare professionals are allowed to bill for this service.

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Virtual check-in guidelines

- For G2012, time spent MUST be documented in the note
- Not separately billable if related to an E/M service provided within the previous seven days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment
- Virtual check-ins can be used for the treatment for the Coronavirus (COVID-19) from anywhere, including places of residence (like homes, nursing homes, and assisted living facilities)
- No frequency limitations at this time
- Co-pays apply

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E-visit CPT codes

Qualified Healthcare Providers who can bill evaluation and management codes within scope of service should utilize the following codes:

99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes

99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

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E-visit CPT codes

Clinicians who can't bill independently bill for evaluation and management visits (i.e. speech therapists, physical therapists, occupational therapists, clinical psychologists) should utilize the codes below:

G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes

G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11–20 minutes

G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

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E-visit guidelines

- E-visits are generally defined as communication between a patient and the provider via an online patient portal
- Medicare **established patients** can have **non-face-to-face patient initiated** communications with there provider without going to the doctors office using online patient portals. This is applicable for all types of locations and in all areas. ***** The established patient requirement has been waived during the COVID 19 pandemic.**
- These codes are for the cumulative time spent over 7 days
- Document the time spent in the note
- Must be unrelated to an E/M service provided within the previous 7 days and is not separately billable if it results in a subsequent face-to-face E/M visit within the next 7 days

Telehealth E/M visits (Effective March 30, 2020)

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- Requires the use of interactive audio and video telecommunications system that permits real-time communication (synchronous communication).
- Medicare requires the place of service code that would have been used if the service had been conducted in person, and modifier 95. Commercial payers may differ.
- Paid at the same rate as regular, in-person visits. Patients must be made aware of potential cost sharing, and their consent to receive the service must be documented.
- For the duration of the public health emergency, Medicare is allowing physicians to select the level of service for telehealth E/M based on medical decision making (as currently defined) or time (defined as all the time associated with the E/M service on the day of the encounter); the current typical times assigned to the E/M codes must be met.

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Telehealth code selection

Service	HCPCS/CPT Code
Office or other outpatient visits	99201-99215
Telehealth consultations, emergency department or initial inpatient	G0425-G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNF's	G0406-G0408
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	99231-99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	99307-99310

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Telehealth CPT code guidance

- Are there video or pictures?
  - If yes, is it real time?
    - If yes, this is telehealth; use E/M codes 99211-99215 for established patients and 99201-99205 for new patients.
    - If no, this is a virtual check-in; use G2010
- If no video or pictures and the communication is to determine if an in office E/M service is necessary?
  - If yes, virtual check-in; use G2012
- If no video or pictures, is the patient on the phone?
  - If no, use e-visit CPT codes 99421-99423
  - If yes, use telephone E/M codes 99441-99443

Medicare telehealth changes (Effective March 30, 2020)

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Removal of Frequency Limitations on Medicare Telehealth

To better serve the patient population that would otherwise not have access to clinically appropriate in-person treatment, the following services no longer have limitations on the number of times they can be provided by Medicare telehealth:

- A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);
- A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
- Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

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Telephone service changes (Effective March 30, 2020)

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CMS will pay for telephone calls utilizing CPT codes 99441—99443, and 98966—98968

- These codes previously had a non-covered status
- Physicians, nurse practitioners, and physician assistants should use codes 99441—99443
- Other qualified health care professionals who may bill Medicare for their services, such as registered dietitians, social workers, speech language pathologists and physical and occupational therapists should use codes 98966—98968
- These are not telehealth services, so do not use POS 02

Telephone service changes (Effective March 30, 2020)

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- Telephone E/M service by a physician or other qualified healthcare professional (allowed for new or established patient during public health emergency)
- Discussion must be initiated by patient, parent, or guardian
- Document reason for communication, pertinent data reviewed assessment, and plan
- Not separately billable if related to an E/M service provided within the previous seven days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment

Telephone service changes (Effective March 30, 2020)

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99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management 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

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98966: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

98967: 11-20 minutes of medical discussion

98968: 21-30 minutes of medical discussion

Medicare telehealth changes (Effective March 30, 2020)

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Remote Patient Monitoring

Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.

For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

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99091: Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

99457: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes

99458: each additional 20 minutes (List separately in addition to code for primary procedure)

99473: Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration

99474: separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Medicare telehealth changes (Effective March 30, 2020)

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99493: Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements:

- tracking patient follow-up and progress using the registry, with appropriate documentation
- participation in weekly caseload consultation with the psychiatric consultant
- ongoing collaboration with and coordination of the patient's mental healthcare with the treating physician or other qualified healthcare professional and any other treating mental health providers
- additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant
- provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies
- monitoring of patient outcomes using validated rating scales, and
- relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment

99494: Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral healthcare manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified healthcare professional. (List separately in addition to code for primary procedure)

Medicare telehealth changes (Effective March 30, 2020)

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Other Medicare Telehealth and Remote Patient Care

- For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one "hands-on" visit per month for the current required clinical examination of the vascular access site.
- For Medicare patients with ESRD, we are exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: Individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.

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Medicare telehealth changes (Effective March 30, 2020)

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- To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.
- Physician visits: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

Medicare telehealth changes (Effective March 30, 2020)

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- In order to bill for any of the services mentioned on the following slides or to bill office visits, you must have a synchronous interactive, real-time audio-visual with the patient.

- In an effort to lower exposure risk, CMS will **temporarily** cover the following CPT codes when provided via telehealth for the duration of the COVID-19 Pandemic.

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Additional telehealth services

- Emergency department visits, levels 1-5 (CPT codes 99281-99285)
- Initial and subsequent observation and observation discharge day management (CPT codes 99217- 99220; CPT codes 99224-99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, all levels (low, moderate, and high complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)

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Additional telehealth services

- 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)

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Additional telehealth services

- Initial and continuing intensive care services (CPT code 99477- 994780)
- 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, 97761, 92521- 92524, 92507)
- Radiation treatment management services (CPT codes 77427)

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Additional telehealth services

Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

A complete list of all Medicare telehealth services can be found here:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

CMS.gov

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Medicare telemedicine changes

- A practitioner providing services via telehealth must be licensed in the state in which the patient is located ** **This has been waived during the COVID 19 pandemic.**
- As of March 16, 2020, and continuing for as long as the designation of a public health emergency remains in effect:

  DEA-registered practitioners in all areas of the United States may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided ALL of the following conditions are met:

  - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
  - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
  - The practitioner is acting in accordance with applicable federal and state laws

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Medicare telemedicine changes

Electronic prescriptions

If prescribing practitioner has previously conducted an in-person medical evaluation of the patient

- May issue a prescription for a controlled substance after having communicated with the patient
- Via telemedicine
- Any other means

NOTE

This is regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services

- So long as the prescription is issued for a legitimate medical purpose, and
- The practitioner is acting in the usual course of his/her professional practice

Billing for professional telehealth services

When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE, along with a modifier 95, indicating that the service rendered was actually performed via telehealth. As a reminder, CMS is not requiring the "CR" modifier on telehealth services.

Billing for professional telehealth services

However, consistent with current rules for traditional telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:

- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

Traditional Medicare telehealth services professional claims should reflect the designated POS code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. There is no change to the facility/non-facility payment differential applied based on POS. Claims submitted with POS code 02 will continue to pay at the facility rate.

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Telehealth service modifiers

Modifier	Description

G0	Telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
	• Effective for claims with dates of service on and after January 1, 2019, modifier G0 is valid for:
	  • Telehealth distant site codes billed with Place of Service (POS) code 02; or
	  • Critical Access Hospitals, CAH method II (revenue codes 096X, 097X, or 098X); or
	  • Telehealth originating site facility fee, billed with HCPCS code Q3014.

GQ	Telehealth service rendered via asynchronous telecommunications system
95	Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System.

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the physician or other qualified healthcare professional.

ICD-10-CM Coding

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ICD-10-CM coding effective February 20, 2019

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Pneumonia

Patients with pneumonia, case confirmed as due to the 2019 novel coronavirus (COVID-19), assign

- J12.89 - Other viral pneumonia

AND

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

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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Acute Bronchitis

Patients with acute bronchitis confirmed as due to COVID-19, assign

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

Bronchitis not otherwise specified (NOS)

Patients with bronchitis (NOS) due to the COVID-19, assign

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

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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Respiratory Infection

Patients with COVID-19 documented as being associated with a lower respiratory infection, not otherwise specified (NOS), or an acute respiratory infection, NOS, assign

- J22 - Unspecified acute lower respiratory infection
  AND
- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

Patients with COVID-19 documented as being associated with a respiratory infection, NOS, assign

- J98.8 - Other specified respiratory disorders
  AND
- B97.29 -Other coronavirus as the cause of diseases classified elsewhere

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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Acute respiratory distress syndrome (ARDS)

ARDS may develop with the COVID-19

Patients with ARDS due to COVID-19, assign

- J80 - Acute respiratory distress syndrome
  AND
- B97.29 - Other coronavirus as the cause of diseases classified elsewhere

According to the Interim Clinical Guidance for Management of Patients with Confirmed 2019 Novel Coronavirus (COVID-19) Infection.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-managementpatients.html

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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Exposure to COVID-19

Patients where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, assign

- Z03.818 - Encounter for observation for suspected exposure to other biological agents ruled out

Patients where there is an actual exposure to someone who is confirmed to have COVID-19, assign

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

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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Signs and symptoms

Patients presenting with any signs/symptoms (such as fever, etc.) and where a definitive diagnosis has not been established, assign codes for the Signs & Symptoms (S&S)

- R05 - Cough
- R06.02 - Shortness of breath
- R50.9 - Fever, unspecified

Note

B34.2 - Coronavirus infection, unspecified, would in generally not be appropriate for the COVID-19

- Cases respiratory in nature

CDC Centers for Disease Control and Prevention

ICD-10-CM coding effective February 20, 2019

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DOCUMENTATION

If the provider documents “suspected,” “possible,” or “probable” COVID-19

DO NOT assign code B97.29 - Other coronavirus as the cause of diseases classified elsewhere

Assign a code(s) explaining the reason for encounter

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

CDC Centers for Disease Control and Prevention

ICD-10-CM coding
New code effective April 1, 2020

Chapter 22

Codes for special purposes (U00-U85)

Provisional assignment of new diseases of uncertain etiology or emergency use (U00-U49)

Note: Codes U00-U49 are to be used by WHO for the provisional assignment of new diseases of uncertain etiology

U07 Conditions of uncertain etiology

ICD-10-CM coding
New code effective April 1, 2020

U07.1 - COVID-19

Use additional code to identify pneumonia or other manifestations.

Excludes1:

Coronavirus infection, unspecified site (B34.2)

Coronavirus as the cause of diseases classified to other chapters (B97.2-)

Severe acute respiratory syndrome [SARS], unspecified (J12.81)

**Official release of information due any day

**Comments made on Coordination Committee Meeting indicate there will be information released regarding the sequencing of this code in the form of additional text to the ICD-10-CM Guidelines

What now?

Where do I start?

Assemble a telehealth implementation team that can make decisions and do research quickly in an effort to launch as soon as possible.

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Some questions to consider

- What do my patients need?
- Does my existing EHR vendor have a telehealth function that can be turned on?
- What is the best remote option for the patient?
- What type of equipment will be required?
- What are the best options for the practice?
- What are the current telehealth coverage and payment guidelines? They will be different based on patient's insurance plan.
- Does provider's malpractice insurance cover telehealth/telemedicine?

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Resources

Medicare Newsroom:

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Medicare Telehealth Fact Sheet:

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

Medicare Telehealth FAQ's:

https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

Medicare Telehealth Codes:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Resources

AMA Quick Guide to Telemedicine Practice:

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice?utm_source=fbpage&utm_medium=social_ama&utm

Telepsychiatry and COVID-19:

https://www.psychiatry.org/psychiatrists/practice/telepsychiatry/blog/apa-resources-on-telepsychiatry-and-covid-19

America's Health Insurance Plans (AHIP) Statement:

https://www.ahip.org/statement-by-the-ahip-board-of-directors-taking-action-to-address-coronavirus-covid-19/

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Questions?

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