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# Telemedicine after COVID-19: What happened and what's next?

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The deadline for this article fell on December 2020. At that time, the world eagerly awaited the broad distribution of vaccines that would stop the spread of COVID-19, which will hopefully be underway by the time of publication.

After the end of the pandemic comes the time to clean up and move forward. In the next few months, public health emergency (PHE) declarations will lapse, closing the door on regulatory flexibilities that have allowed healthcare organizations to devote more resources to patient care. Compliance professionals may find that they have two distinct but related priorities in the next few months: (1) assessing their organizations' compliance with new (or newly restored) regulatory and billing requirements and (2) helping their organizations chart a path forward.

The rapid expansion of virtual care services—referred to as telemedicine and telehealth in this article—will be a lasting legacy of the COVID-19 pandemic. Telemedicine presents compliance risks looking both backward and forward. While Medicare, Medicaid, and commercial payers modified billing rules to facilitate a shift to virtual care, it is only half of the picture. The practice of medicine, including telemedicine, is still fundamentally a question of state-by-state regulation, which will likely lead to friction as compliance professionals and their colleagues move toward a future in which patients expect to access their providers from home.

## What happened? Auditing telemedicine claims

In October 2020, the Office of Inspector General announced its plan to audit telehealth services that occurred during the COVID-19 pandemic.[1] The review will focus on professional fee services for traditional Medicare and Medicare Advantage plans and will detect program integrity risks related to telehealth services during this time. The Office of Inspector General will use data analytics to focus on provider billing patterns and to identify outliers when compared to other same-specialty practices. In light of this specific enforcement priority, compliance professionals should consider including telemedicine claims reviews into their work plans for 2021.

### Where was care provided and received?

When billing telemedicine services, geography plays a critical role in compliance. Prior to the COVID-19 PHE waivers,[2] the provider location (distant site) and the patient location (originating site) had to meet strict

eligibility requirements to be able to bill for a remote service as if it had been provided in-person. The PHE waivers relaxed definitions for both locations, leading to situations where both providers and patients stayed in their own homes during a medical encounter that was billable as if it had taken place in person.

Even though the Centers for Medicare & Medicaid Services (CMS) has relaxed its standards for where remote services may be provided, providers must still be diligent in how they document and bill the encounters. Prior to the pandemic, distant site providers billed an evaluation and management (E/M) encounter with place of service 02 to indicate a telemedicine visit, and reimbursement was slightly discounted compared to the standard E/M fee. The originating site billed for its role facilitating the patient's visit with use of the room and qualifying equipment using code Q3014. Taken together, the discounted distant site reimbursement and the originating site flat fee constituted Medicare's full reimbursement for the service.

During the COVID-19 emergency, CMS's billing guidelines have been adjusted for both originating sites and distant sites. When the patient is at home, or at least not presenting at a medical facility, the Q3014 facility flat fee is not billed because no medical facility is acting as the originating site. CMS has instructed providers to bill telemedicine services where the provider's site (distant location) was away from the medical office with the place of service that they would have used if the service were *not* a telemedicine encounter prior to the PHE, and to add modifier -95 to the claim.[3] Modifier -95 indicates the use of a two-way, synchronous, audiovisual communication between the provider and patient.

Compliance professionals should be aware of these modified requirements and consider including telemedicine claims reviews into their 2021 work plans. In addition, compliance professionals should acknowledge that telehealth is still maturing, so government and commercial payer requirements could change significantly. Consider the organization's change management process as it relates to billing telemedicine services. Which unit is responsible for ingesting new billing requirements, training key employees, and monitoring their performance to verify that the updated requirements are being met?

## What services are billable only when provided remotely?

The well-publicized expansion of telemedicine during the COVID-19 pandemic could create an impression that any care provided virtually is always billable on the same terms as an in-person visit. This is not the case. CMS and other payers have recognized that there is nuance in the time and effort required for various types of virtual visits, and providers are required to code and bill for their services appropriately. The following visit types are specifically recognized as payable by CMS or other payers but are not considered telemedicine visits:[4]

- Virtual check-ins. Professionals bill for brief (5–10 min) communications that mitigate the need for an in-person visit and can be furnished via any synchronous telecommunications technology. During the PHE waivers, both new and established patients can receive these services. The virtual check-in must not be related to any medical visit in the next 24 hours or previous seven days. If all criteria are met, providers can bill for this service using code G2012.

- Audio-only telephone communications. During the PHE, Medicare and many private payers have approved coverage of telephone-only (no video) services billed using an existing set of three CPT codes. Per CPT guidelines, physicians use code range 99441–99443, while other qualifying nonphysician healthcare professionals use code range 98966–98968.

- Remote evaluation. A professional evaluates a prerecorded video or image the patient sends to the provider. Provided all criteria are met, the service can be billed using code G2010.

- E-visits. An established patient can generate an initial non-face-to-face encounter via an online patient

portal. Providers bill for this online E/M service for time accumulated over seven days using codes 99421–99423. Healthcare professionals that do not qualify for billing E/M services can bill their time in the same way, accumulated over seven days. The qualified nonphysician healthcare professionals include psychologists, speech language pathologists, occupational therapists, and physical therapists. These professionals may use codes G2061–G2063.