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Billing and coding for telehealth services during the COVID-19 public health emergency

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On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) announced expanded Medicare coverage of telehealth services[1] on a temporary and emergency basis pursuant to waiver authority added under section 1135(b)(8) of the Social Security Act by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. Effective March 6, 2020, Medicare started paying for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's residence. In the context of the public health emergency (PHE) for the COVID-19 pandemic, CMS recognized that physicians and other healthcare professionals, as well as others, including Medicare beneficiaries, are faced with new challenges regarding potential COVID-19 exposure risks.

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through an electronic communication to improve a patient's health. There are three main types of virtual services physicians and other professionals may provide to Medicare beneficiaries. Those services, which are summarized in the March 17, 2020, CMS fact sheet, are telehealth visits, virtual check-ins, and e-visits.

What is the telehealth 1135 waiver?

Under this waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country, including in a patient's residence. A full range of providers, such as doctors, nurse practitioners, clinical psychologists, licensed clinical social workers, and therapists are able to offer telehealth to their Medicare patients under the COVID-19 telehealth waiver.

Telehealth before COVID-19

Prior to the waiver, Medicare would only pay for telehealth services on a limited basis—when the person receiving the service was in a designated rural area (e.g., the beneficiary getting the services would have to live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location). In addition, the beneficiary generally could not get telehealth services in their home.

Even before the COVID-19 telehealth waiver, CMS made several related changes to improve access to virtual care. In 2019, Medicare started providing coverage for brief communications or virtual check-ins, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B also separately pays clinicians for e-visits, which are "non-face-to-face patient-initiated communications through an online patient portal." Prior to the PHE, Medicare billing for telehealth services performed "through an asynchronous

telecommunications system" would require the telehealth GQ (via an asynchronous telecommunications system) modifier with the professional service Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code (for example, 99201 GQ).[2] The GQ modifier could also certify the asynchronous collection and transmission of a medical file to the distant site from a federal telemedicine demonstration project conducted in Alaska or Hawaii. Telehealth service claims would use Place of Service (POS) 02-Telehealth to indicate the provider furnished the billed service as a professional telehealth service from a distant site.