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Coding for Telemedicine

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Telemedicine: Critical Action During a Crucial Time

The COVID-19 public health emergency (PHE) has disrupted our ability to care for our patients. That is why both commercial and federal payers expanded telemedicine options and created, with unprecedented speed, waivers or flexibilities within existing rules. However, there is no consistency among the payers making coding for telemedicine confusing and challenging.

In these uncertain times brought about by the PHE, patients are sometimes reluctant to leave home and enter physician offices, even for exams, tests and procedures that they need and want. Data from multiple large healthcare systems demonstrate that a personal call from the physician is far more valuable and effective than a call from staff in helping them return for care. This appears to be particularly true if the physician takes a few minutes to speak to the actions taken to keep patients and staff safe and to articulate the need for continued care or surgery. Nothing appears to be more effective than the personal relationship between patient and physician. Telemedicine is the mechanism that reinforces and strengthens that relationship.

What is Telemedicine

The terms telemedicine and telehealth are interchangeable. They are defined as real-time interactions, over audio and video telecommunications systems, between a physician or other qualified health care professional (one who is licensed to practice medicine) and a patient who is located at a distant site from the physician. Many telemedicine codes are identified by an asterisk (*) in your CPT code book.

Regulatory Flexibilities During the COVID-19 PHE

Note: All of these new flexibilities are subject to review.

- **All telemedicine rules apply to new and established patients.**
- **Patients must be notified** that a claim will be submitted to the payer.
- **Non-HIPAA compliant communications platforms** are allowed during the PHE, as long as they are not public facing. Examples of non-public facing remote communication products, include

VIDEO CHAT APPLICATIONS	TEXTING APPLICATIONS
<ul style="list-style-type: none"> • Apple FaceTime • Facebook Messenger video chat • Google Hangouts video • Whatsapp video chat • Skype. 	<ul style="list-style-type: none"> • Signal • Jabber • Facebook Messenger • Google Hangouts • Whatsapp • iMessage

- **These rules apply to Medicare Part B patients:**
 - **Appending modifier -95** (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications systems) is required for Medicare Part B patients during the PHE. Commercial plans have different modifier requirements
 - **List place of service as 11 Office for Medicare Part B patients.** A physician may conduct telemedicine from his/her home and continue to report 11 as place of service. There is no need to add physician home as a place of service during the pandemic. Commercial plan rules may vary.
- **Phone call codes G2012 or 99441-99443** should not be reported when originating from a related E/M service provide within the past seven day nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment. Also, should not be reported for postop visits.
- **E-visit codes 99421-99423** include up to seven days cumulative time. These codes are not to be used for scheduling appointments or conveying test results.
- **Evaluation of video or images code G2010** should be used for remote evaluation of recorded video and/or images submitted by a new or established patient (e.g., store and forward), including interpretation with follow-up with the patient with 24 business hours, not originating from a related E/M service provided within the previous seven days nor leading to an E/M services or procedure within the next 24 hours or soonest available appointment. G2010 and G2012 may be submitted the same day.
- **Eye visit codes are included in the list of covered exams** during the PHE as of April 30 per the Centers for Medicare & Medicaid Services (CMS). Documentation requirements remain the same:
 - 92002 and 92012 are achievable via virtual face-to-face interaction. Place of service is 11 and append modifier -95.
 - This expansion of coverage may be unique to CMS.
- Time involving staff who are not licensed to practice medicine cannot be billed for or factored into time-based coding options. **Effective April 30, CMS includes the technician code 99211 as a telemedicine code option.**
 - Applies to new and established patients.
 - There must be a documented order from the physician indicating what should be addressed during the staff/patient encounter by phone.
 - Supervision may be virtual.
 - 99211 continues to be bundled with all testing services performed the same day.
 - A physician visit performed on the same day of 99211 would not be separately billable.
- **Both HCPCS codes G2010 and G2012** may be billed by the same physician for the same patient on the same day as long as the requirements for both codes have been met.

- **Residents can furnish telehealth services** for the duration of the PHE under direct supervision of the teaching physician when provided by interactive telecommunications technology.
- Section 3709 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act **temporarily suspends the 2% payment adjustment** currently applied to all Medicare Fee-for-Service (FFS) claims due to sequestration. The suspension is effective for claims with dates of service from May 1 through December 31, 2020.
- **Testing services under direct supervision are now general supervision** through the duration of the PHE.
- **Health and Human Services (HHS) will not conduct audits** to ensure that a prior relationship (new vs. established patient) existed for claims submitted during the PHE.

TIP

To learn about risk management issues, visit The Ophthalmic Mutual Insurance Company (OMIC) at <https://www.omic.com/covid-19-page/>

Other Waivers During the COVID-19 PHE

Physician Licensing

CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state. CMS will waive the physician or non-physician practitioner licensing requirements when the following four conditions are met:

1. Must be enrolled as such in the Medicare program;
2. Must possess a valid license to practice in the state, which relates to his or her Medicare enrollment;
3. Is furnishing services – whether in person or via telehealth – in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and,
4. Is not affirmatively excluded from practice in the state or any other state that is part of the 1135 emergency area.

Note: In addition to the statutory limitations that apply to 1135-based licensure waivers, an 1135 waiver, when granted by CMS, does not have the effect of waiving state or local licensure requirements or any requirement specified by the state or a local government as a condition for waiving its licensure requirements. Those requirements would continue to apply unless waived by the state. Therefore, in order for the physician or non-physician practitioner to avail him- or herself of the 1135 waiver under the conditions described above, the state also would have to waive its licensure requirements, either individually or categorically, for the type of practice for which the physician or non-physician practitioner is licensed in his or her home state.

Physician Enrollment

During the PHE, CMS implemented these changes to the physician enrollment process.

- Postpone all revalidation actions.
- Allow licensed providers to render services outside of their state of enrollment.
- Expedite any pending or new applications from providers.
- Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.
- Allow opted-out physicians and non-physician practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.

Locum Tenens

- CMS is modifying the 60-day limit in section 1842(b)(6)(D)(iii) of the Social Security Act. The change allows a physician to use the same substitute for the entire time he or she is unavailable to provide services during the COVID-19 PHE plus an additional period of no more than 60 continuous days after the PHE expires.
- On the 61st day after the PHE ends (or earlier if desired), the regular physician must use a different substitute or return to work in his or her practice for at least one day in order to reset the 60-day clock.
- Without this flexibility, the regular physician or physical therapist generally could not use a single substitute for a continuous period of longer than 60 days and would instead be required to secure a series of substitutes to cover sequential 60-day periods.
- The modified timetable applies to both types of substitute billing arrangements under Medicare fee-for-service (i.e., reciprocal billing arrangements and fee-for-time compensation arrangements (formerly known as locum tenens)).
- As provided by law, a regular physician or physical therapist who has been called or ordered to active duty as a member of a reserve component of the Armed Forces may continue to use the same substitute for an unlimited time even after the emergency ends.

Note: Medicare can pay for services under a substitute billing arrangement only when the regular physician is unavailable to provide the services.

Overview of Five Covered Telehealth Options for Medicare Part B Patients Including Hybrid Exams

There are four options for telehealth and other communications-based technology services. Hybrid exams are a fifth option.

This information is based on CMS's guidelines.

Examples of commercial payer variations are addressed in another section.

Option 1: Telehealth Virtual Two-Way Communication Between Physician and Patient

Level of exam is based on either physician total time (listed below) on the date of the encounter or medical decision making (MDM) during the PHE.

E/M Codes for New Patients

CPT CODE	LEVEL OF MDM	TIME	MODIFIER	PLACE OF SERVICE
99201	Straightforward	10 min	95	11
99202	Straightforward	20 min	95	11
99203	Low	30 min	95	11
99204	Moderate	45 min	95	11
99205	High	60 min	95	11

Eye Visit Codes for New Patients

CPT CODE	DESCRIPTION	MODIFIER	PLACE OF SERVICE
92002	New patient Intermediate exam	95	11
92004	New patient Comprehensive exam	95	11

E/M Codes for Established Patient

CPT CODE	LEVEL OF MDM	TIME	MODIFIER	PLACE OF SERVICE
e	Doesn't qualify	5 min	95	11
99212	Straightforward	10 min	95	11
99213*	Low	15 min	95	11
99214	Moderate	25 min	95	11
99215	High	40 min	95	11

Eye Visit Codes for Established Patient

CPT CODE	DESCRIPTION	MODIFIER	PLACE OF SERVICE
92012	Established patient Intermediate exam	95	11
92014	Established patient Comprehensive exam	95	11

***Example of Medical Decision Making for 99213**

Must meet two of the following criteria:

- ☐ Established problem to examiner: stable, improving or resolved
- ☐ Established or new problem to examiner: worsening (only one necessary)
- ☐ Clinical lab test(s): ordered or reviewed
- ☐ Radiology tests: ordered or reviewed
- ☐ Other diagnostic tests: ordered or reviewed
- ☐ Review of old records and/or additional history from other than the patient

Must meet one of the two categories:

PRESENTING PROBLEM(S)	MANAGEMENT OPTIONS SELECTED
<ul style="list-style-type: none"> • Two or more self-limited or minor problems • One stable chronic illness • Acute uncomplicated illness or injury 	<ul style="list-style-type: none"> • Over-the-counter drugs or RX • Minor surgery recommended with no identified risk factors

Option 2: Physician/Patient Phone Calls

CPT CODE	TIME	MODIFIER	PLACE OF SERVICE
G2012	5-10 min	N/A	11
99441	5-10 min	N/A	11
99442	11-20 min	N/A	11
99443	21-30 min	N/A	11

Important: Effective April 30, CMS increased the allowable of 99441 to 99212, 99442 to 99213 and 99443 to 99214. The increase will be automatically made to March 1 dates of service. These codes are reported for medical discussion with the physician and should not be used for administrative or other non-medical discussion with the patient.

Clinical Vignettes for CPT codes 99441-99443

- **99441** – A new or established patient known to the physician calls with a new complaint. The physician obtains a brief history and the patient's present medication use and makes treatment recommendations, all of which are recorded in the patient's medical record. The patient is instructed and advised to call if the symptoms fail to improve with the recommended treatment. The call lasts 8 minutes. No office visit is required.
- **99442** – A new or established patient calls the office of a physician to discuss new acute illness symptoms. The physician obtains a brief history and makes treatment recommendations, all of which are recorded in the patient's medical record. The patient is instructed and advised to call if symptoms are increasing. The call lasts 15 minutes. No office visit is required.
- **99443** – A new or established patient with special needs calls to discuss onset of new and disturbing symptoms. During a 25-minute phone call, the physician reviews the history and review of systems, the description of symptoms, and current medications. She makes a recommendation to change the present medication regimen, provides reassurance, both of which are recorded in the patient's medical record, and requests follow-up in the office in one week or sooner if needed.

Option 3: E-Visits for Online Digital Services

CPT CODE	TIME	MODIFIER	PLACE OF SERVICE
99421	5-10 min	N/A	11
99422	11-20 min	N/A	11
99423	21 or more min	N/A	11

Option 4: Evaluation of Video and Images

CPT CODE	DEFINITION	MODIFIER	PLACE OF SERVICE
G2010	Remote evaluation of recorded video and/or images submitted by a new or established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours		

Option 5: Hybrid Exams

Telemedicine options improve patient capacity by reducing in-office schedules due to social distancing requirements and requests. Histories taken by phone and drive-up IOP checks are the new normal for many practices. Along with offering telemedicine appointments for minor conditions, expanding the encounter to include recent testing services may increase treatment options. Consider the following telemedicine hybrid scenarios:

Scenario #1: A 70-year female schedules a follow-up for nonexudative age-related macular degeneration.

- Staff obtains and documents history in the medical record.
- The patient is COVID-19 high-risk for severe illness; a telemedicine hybrid appointment is offered based on the clinic scheduling protocol.
- The physician reviews the chart and assesses the previous exam, visual acuity and findings.
- A retina OCT is ordered and documented in the medical record.
- The patient is scheduled for a visual acuity and OCT at the satellite office closest to her home.
- A subsequent telemedicine appointment with the ophthalmologist is scheduled at the next convenient date and time.
- At the satellite office, a technician tests visual acuity and conducts an OCT clinic, scheduled 30 minutes apart for social distancing. There is no wait for the patient and additional time is allotted for sanitation between tests.
- During the telemedicine appointment, the physician reviews the history, visual acuity, and OCT, discusses the findings and provides recommendations to the patient.

Scenario #2: A 62-year old male is recalled for a 4-month glaucoma check.

- After reviewing the patient's chart and previous visual field and glaucoma OCT, the physician considers telemedicine options due to the lack of availability for a timely clinic appointment.
- The patient is scheduled for an IOP check at the next available drive-up clinic, with a follow-up telemedicine appointment with the physician.
- The follow-up telemedicine encounter is conducted. The physician reviews the IOP, discusses current medications and findings, and provides recommendations to the patient.

BOTTOM LINE

When utilizing telemedicine hybrid encounters consider the following:

- Physicians should direct the scheduling of telemedicine hybrid encounters based on patient-specific criteria or a comprehensive clinical scheduling protocol.
- All delegated testing services require a physician order that is documented prior to the encounter.
- Patients must verbally consent to the telemedicine encounter.

Telemedicine Performed in Locations other than Office

Coding for Nursing Home Visits

- To be reported when the MD, DO, OD visits the patient in a Nursing Home.
- Place of service is 13
- New Patient: 99324, 99325, 99326, 99327, 99328
- Established Patient: 99334, 99335, 99336, 99337

Modifier -25 Note: When billing an intravitreal injection (or any minor surgery) the same day as an encounter, consider the definition of modifier -25 and although medically necessary, if the established patient exam is performed solely to confirm the need for the injection, the exam is not separately billable

Coding for Home Visits

- To be reported when the MD, DO, OD visits the patient at their home.
- Place of service is 12
- New Patient: 99341, 99342, 99343, 99344, 99345
- Established Patient: 99347, 99348, 99349, 99350

Modifier -25 Note: When billing an intravitreal injection (or any minor surgery) the same day as an encounter, consider the definition of modifier -25 and although medically necessary, if the established patient exam is performed solely to confirm the need for the injection, the exam is not separately billable

Coding for Skilled Nursing Home Visits

- To be reported when the MD, DO, OD visits the patient in the Skilled Nursing Facility.
- Place of Service is 13.
- Initial visit whether patient is new or established 99304, 99305, 99306
- Subsequent Skilled Nursing Facility visits performed in person or via telehealth: 99307, 99308, 99309, 99310

Variations with Commercial Plans

Best practices create a worksheet outlining variations in commercial payer requirements. This is an example only. Requirements may not be the same for your state and payer mix.

PAYER	PLACE OF SERVICE AND MODIFIER REQUIREMENTS
Aetna	02 POS and GT Modifier
Aetna Better Health	02 POS and GT Modifier
BlueCross Complete	02 POS and GT Modifier
Cigna	02 POS and GQ Modifier
Humana Military	02 POS and GT Modifier
McLaren	02 POS and GT Modifier
Medicaid - Michigan	02 POS and GT Modifier
Meridian	02 POS and GT Modifier
Molina Medicaid	02 POS and GT Modifier
Molina Market Place	02 POS and 95 Modifier
Total Health Care Commercial	02 POS only
Total Health Care Medicaid	02 POS and GT Modifier
UMR (follows UHC)	02 POS and GT Modifier
United Healthcare	02 POS and GT Modifier

Additional Resources

Visit aao.org/coding often to find answers to all your documentation and coding questions. Content is updated daily. For example, *“Thyroid Eye Disease Infusion Treatment: Effective July 1, 2020, Report HCPCs code C9061 when injecting TEPEZZA teprotumab-trbw, 10 mg.”*

Questions not addressed in this document may be emailed to coding@aao.org.



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