Telemedicine & Coding Tips in the Era of COVID

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What is Telemedicine?

A Telehealth Taxonomy

- Tele Education
- Telemedicine
- Patient Portal
- Interactive Patient Care
- Remote Patient Monitoring
- Store and Forward
Why Telemedicine?

- Clinical shortage
- Poor distribution
- Underserved
- Windshield time
- Delay in treatment
- Language barriers
Telemedicine in MFM (TeleMFM)

- Store and Forward
  - Ultrasound interpretation
- Outpatient Medicine
  - Consultation
  - Genetic counseling
  - Diabetic education
- Inpatient Medicine
  - Consultation
  - Antepartum management
  - Ultrasound interpretation
Who has been doing TeleMFM?

- Academic Institutions
  - Predominantly outpatient
  - Large component: consultations
- Regional Private Institutions
  - Predominantly outpatient
  - Large component: ultrasound reads
- National Groups
  - Hybrid due to ROI
What do I need?

The Tools depends on the location:

- Proximal end: you!
  - Home office
  - Medical office
- Distal end: Them!
  - Satellite clinic (outpatient)
  - D2C (outpatient)
  - Hospital (inpatient)
What do I need? Proximal (you):
What do I need? Distal (them):
What do I need? Distal (them):
Common telemedicine rules

• Know your state rules: www.CCHPCA.org
  • It’s where the patient is, not you!
• Know your best practices: www.AmericanTelemed.org
  • The service should be the same as in-person
• Pick the right technology partner
  • Not all platforms are created equal
• Figure out the informed consent process
• BAA/HIPAA/Indemnity
  • Have a “Legal Eagle” overview the process
Common telemedicine rules

- Licensure (cross-state practice)
  - It’s where the patient is, not you!
- Anti-Trust Law/Stark
  - Must pass the sniff test!
- Record keeping
- Prescribing rules & regulations
- If getting started, go to: HealthSectorCouncil.org, click on resources, and read the AHIMA Telemed Toolkit!
New CMS guidance for COVID

- Only active while under emergency declaration
- Full parity (there is a catch!)
  - Check with your payors
- No audit
- Limited HIPAA constraints
  - No TikTok, Twitch, FB Live, or Instagram
- Billing requirements
  - Name x2, Date, Codes!
Will I get paid?

• Parity law
  • Just because its there, its not followed!
• Transmission/facility fee
  • State specific (check the Q-code)
• Originating site restriction
  • Its not restricted to rural anymore
• RPM and Store/Forward lag
  • Only 22 states offer rules
Will I get paid?
Will I get paid?

[Map showing states with eligible originating site lists]
Will I get paid?

Private Payer Law Map in 2012:
Will I get paid?
Segway to Vanita...

How I wrap up my notes...

Home to office:
A total of 30 minutes was spent with greater than 50% spent in face-to-face counseling via telemedicine, and coordinating care with the patient in discussing the above diagnoses and management plan. The patient was seen via telemedicine in our satellite office, while I performed the consultation from my home office in Park City, Utah. Informed consent to proceed with telemedicine visit was obtained by clinic staff.

Office to office:
A total of 30 minutes was spent with greater than 50% spent in face-to-face counseling via telemedicine, and coordinating care with the patient in discussing the above diagnoses and management plan.
Coding Tips in the Era of COVID

Vanita D. Jain, MD
Chair, SMFM Coding Committee
Coding resources

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Updated Interim ICD-10-CM Coding Guidance: Recommended Coding for COVID-19 and pregnancy

The Society for Maternal-Fetal Medicine (SMFM) Coding Committee; Steve Rad, MD; Trisha Malisch, CCS-P, CPC, Vanita Jain, MD


Since our last publication, in an unprecedented exception, the WHO and CDC have announced approval of a new emergency code for COVID-19 in the US: U07.1 (COVID-19; 2019-nCoV acute respiratory disease) [https://www.cdc.gov/nchhstp/icd/icd10cm.html]. This code would replace use of code B97.29, which is not exclusive to the 2019-nCoV virus responsible for the COVID-19 pandemic and does not distinguish the more than 30 varieties of coronaviruses. Due to the urgent need to uniquely identify COVID-19, the new emergency U07.1 code was approved. This code will be added to the US ICD-10-CM list effective April 1, 2020 (instead of the usual October cycle).

Starting April 1, U07.1 should be used to report a patient that has tested positive as confirmed by laboratory testing for COVID-19. This code is not be used retrospectively for cases prior to April 1. Until then and for all cases prior to April 1, coding guidance from the earlier SMFM Coding Committee document and CDC should be applied.

Here we summarize proper use of the U07.1 ICD-10-CM code in the MFM setting. As information about COVID-19 is rapidly evolving, coding guidance may change as new clinical information and guidelines become available.

Maternal Exposure/Symptoms/Confirmed Cases

In the setting of pregnancy, codes from ICD-10-CM Chapter 15 (Pregnancy, Childbirth, and Puerperium) should be sequenced first before codes from other ICD-10-CM chapters. COVID-19 infections can cause a range of maternal illness,
How do you code for COVID

Unprecedented exception from the usual October cycle, WHO & CDC announced a new code for COVID-19: U07.1 (COVID-19; 2019 nCoV acute respiratory disease)

This code was effective starting April 1st, 2020
Used when treating a patient that has a confirmed laboratory positive test result

Prior to April 1st, please refer to our Coding tip from March but if retroactively submitting claims use B97.29
Coding for COVID

In pregnancy utilize O codes (chapter 15) FIRST
In the office/consult/prenatal care:
- Consider O99.51 – disease of the respiratory system complicating pregnancy
- Consider O98.51 – other viral disease complicating pregnancy

Then follow with your COVID code (U07.1)
Then any other symptoms or diagnosis
  ex. R codes for cough, SOB, fever
  ex. J codes for bronchitis, hypoxia, ARDS
Examples of office scenarios

25 year old G1P0 at 13 weeks presents with diagnosed COVID-19 infection, no symptoms
O98.511
U07.1
Z3A.13

25 year old G1P0 at 32 weeks, COVID-19 +, with pneumonia based on CXR
O98.513
U07.1
Z3A.32  ** normally would think add J12.81 (PNA) but this is an excludes rule with U07.1
Imaging for COVID

Current SMFM guidelines suggest a mid-trimester anatomy ultrasound and third trimester growth may be appropriate based on clinical scenario.

Again, utilize your O codes FIRST:

O35.3XX#
(maternal care for suspected damage to fetus from viral disease in mother)

O36.59X#
(maternal care for other known or suspected poor fetal growth)
Coding for imaging COVID related

23 year old G1P0 at 20 weeks with previous COVID+ status at 16 weeks

76811
O35.3XX0
O98.512
U07.1
Z3A.20
Coding for COVID related imaging

23 year old G1P0 at 35 weeks, previous COVID+ infection earlier this pregnancy, post anatomy

76816
O36.5930
O98.513
U07.1
Z3A.35
Updated Interim Coding Guidance: Coding for Telemedicine and Remote Patient Monitoring Services during the COVID-19 Pandemic

The Society for Maternal-Fetal Medicine (SMFM) Coding Committee; Steve Rad, MD; Dave Smith, CPC, MBA; Trisha Malisch, CCS-P, CPC; Vanita Jain, MD

The purpose of this document is to provide maternal-fetal medicine subspecialists interim coding guidance for telemedicine and remote patient monitoring services during the COVID-19 Public Health Emergency.

The SMFM Coding Committee recently shared guidance on ICD-10-CM coding for COVID-19 and pregnancy (log in required: https://www.smfm.org/coding/ips/138-interim-icd-10-cm-coding-guidance-recommended-coding-for-covid-19-and-pregnancy). Telemedicine is an essential and beneficial tool for providing care to pregnant woman during the COVID-19 Public Health Emergency and is increasingly used in nearly every aspect of contemporary obstetrics and gynecology. The American College of Obstetricians and Gynecologists (ACOG) recently published the 2020 Committee Opinion 798 Implementing Telehealth in Practice, supporting the use of telehealth to enhance care (https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/implementing-telehealth-in-practice). The SMFM recently called on payers to work with OB care providers to ensure appropriate and adequate coverage and reimbursement for remote pregnancy care in order to enable social spacing and minimize the risk of virus exposure for at-risk women (https://s3.amazonaws.com/cdn.smfm.org/media/2264/c4ceb382b8428d22cbeb2c5d5690633f-regular.png). Under the recently enacted legislation Coronavirus Preparedness and Response Supplemental Appropriations Act and 1135 Waver Authority, the Centers for Medicare & Medicaid Services (CMS) on March 17, 2020 broadened access to Medicare telehealth services for Medicare beneficiaries under a temporary and emergency basis in order to increase access to medical care while helping to contain the community spread of this virus.
Telemedicine

Telemedicine consultations require the same elements as those required in regular face-to-face consultations:

(1) Request for consultation
(2) Opinion
(3) Written Report.
As noted earlier, CMS has expanded and temporarily removed some restrictions specifically for Medicare beneficiaries during these emergency times (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet).

Key Highlights are:

1. Ability to use video conferencing software that doesn't meet HIPAA requirements (Skype, FaceTime, Duo, etc.)
2. Can use for new patient as well as established
3. Originating site waived - can be patient home, rather than clinic or other health care facility
4. Patients do not need to be located in a rural area
5. Services are not limited by patient diagnosis, and certainly not only limited to COVID-19 related care
6. April 1 update. On an interim basis, E/M visit code level for office/outpatient telehealth services (CPT 99201-99215 ONLY) may be selected based on either the level of MDM (medical decision-making complexity) or time, with time defined as all of the time associated with the E/M on the day of the encounter (total time including face-to-face and non-face-to face-time); and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to policy that will apply to all office/outpatient E/M encounters beginning in 2021.
7. April 1 update: On an interim basis, CMS is instructing that POS code 02 not be used and instead to report the POS code that would have been reported had the service been furnished in person. CMS is requesting use of CPT modifier 95 to be applied to claim lines to describe services furnished via telehealth. This interim change will allow for appropriate payments at the same rate as if the services were furnished in person.

Furthermore, all states have broad flexibility to cover telehealth through Medicaid. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs (https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf). We anticipate many state programs will be following suit and expanding restrictions. If not, SMFM members are encouraged to share with their Medicaid contacts to ask that these expansions apply to Medicaid services as well. We cannot comment on whether commercial payers will be following suit with CMS changes and encourage you check with your individual payers directly. Lastly, these changes are temporary/interim and apply only to Medicare beneficiaries at this time and once the pandemic public health emergency is considered over, rules and restrictions may revert back to prior pre-pandemic policies.
Telemedicine update

-HIPPA compliance questions: Office of Civil Rights

-ANY non-public facing remote communication product that is available to communicate with patients. Facebook Live, Twitch, TikTok, and similar video communication applications that are public facing, should NOT be used

-Some states have waived the direct face to face requirement and are accepting regular telephone calls as telemedicine encounters (with the same billing as advised above) during the COVID-19 emergency
Telephone/Audio only concerns

Physician/ Advanced Practitioner Services  (Established Patient):
  99441  5-10 minutes
  99442  11-20 minutes
  99443  21-30 minutes

Non-physician Services  
  (Established Patient):
  98966  5-10 minutes
  98967  11-20 minutes
  98968  21-30 minutes
Telephone/Audio only concerns

Previously RULES included

• Services must be initiated by the patient
• Used for established patient only
• Must not originate from E/M performed within the previous 7 days
• Cannot bill if telephone service leads to an E/M or procedure within the next 24 hours or earliest available appointment
Telephone/audio documentation

- Document date and time and content of phone discussion
- Total time of the phone call must be documented
- Location of the provider and the patient should be documented
- Include instructions given and patient understanding of instructions
- Document all follow-up calls with patient or other providers
- Include tests ordered and any referrals made
- If other physicians/clinical staff are involved in decision-making, document their input
- Sign and date medical record entries
Ultrasound – simple remote reading options

"1" - Procedure must be performed under general supervision. General supervision means the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

"2" - Procedure must be performed under direct supervision. Direct supervision generally means to be physically present, or within an immediate distance, such as on the same floor, and available to respond to the needs of something or someone. If billed, these studies cannot be interpreted remotely while away on travel.

"3" - Procedure must be performed under personal supervision. Personal supervision is defined as the physician must be in attendance in the room during the performance of the service or procedure.

"9" - Concept does not apply.
Remote reading

Appropriate use of modifiers

- 26 (professional component)
- TC (technical component)
- 25 (separate E/M service on same day as procedure)

Ex.

Facility performs ultrasound and the MFM physician interprets
MFM physician bills the procedure code professional component for that service with modifier 26
Facility bills the same procedure code with modifier TC if this separation is applicable.
IF MFM also discusses abnormality seen, -25 is used to report a separate Evaluation and Management (E/M) service
What about ‘curbside’ consults

MFM subspecialists frequently are asked by other physicians to provide assistance, opinion and consultation to assist in the diagnosis, management, and treatment of patients without a face-to-face visit.

Interprofessional Codes can be considered.

The codes are all time-based codes and provided by phone, internet or electronic health record documentation.
Interprofessional Codes

MFMs who communicate with referring OBGYN (or other MD) regarding a diagnosis or management of a patient.

These codes are defined as an E/M service in which a patient’s treating provider (OBGYN attending) requests the opinion and/or treatment advice of a consultant (MFM attending) with specific specialty expertise to assist the OBGYN in the diagnosis or management of a patient’s problem.

These services are utilized to help bill/code appropriately for team-based approaches to care, and do NOT include physician time with the patient. There is no face-to-face encounter on the part of the MFM (consultant).

These codes were updated in 2019 to include assessment of the EMR (electronic medical record) as part of the consultation service. Since the type or severity of the problem is not defined, any condition may qualify for consultative services.

Only the consultant (ie, MFM) can report these codes. Codes require both a verbal and written follow-up report.
Interprofessional codes

99446: interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified healthcare professional; 5-10 minutes of medical consultative discussion and review

- 99447: ...11-20 minutes
- 99448: ...21-30 minutes
- 99449: ...31 minutes or more
Interprofessional Codes

- Only reported by the consultant (MFM) when requested by another provider
- Can only be reported once in 7 days for the same patient
- Are reported based on cumulative time for those 7 days (even if you consult every day)
- Can NOT be used if a transfer of care or face-to-face consult occurs within next 14 days
- Can NOT be used if you (MFM) saw the patient for face-to-face time in the last 14 days
- Majority of time must be medical consultative verbal or internet discussion (greater than 50%), and appropriately documented. If greater than 50% is in data review and/or analysis, do not bill these codes.
- Written or verbal request should be documented in the patient’s medical record, including the reason for the consult