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COVID-19 CPT CODING FAQS

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These answers are accurate as of April 2020

Q: Are the E/M codes in series 99201-99205 and 99212-99215 for audio only? For non-face-to-face telephone "audio-only" services, can you tell if E/M codes 99201-99205 and 99212-99215 can be billed? Or is just HCPCS code G2012 and CPT codes 99441-99443?

A: ***At the time of this publication, E/M services 99201-99215 can not be performed via telephone only; however, CMS has modified the current telehealth services so that a number of counseling services can be telephone only. We encourage you to visit the current telehealth list and monitor frequently, as changes are likely to continue. It can be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.***

CMS writes in the interim final rule:

Section 102 of the Coronavirus Preparedness and Response Supplemental Appropriation Act 2020 gives the secretary the authority to waive: (1) the telehealth originating site requirements under section 1834(m)(4)(C) of the Act (both geographic and site of service) for telehealth services furnished in an emergency area; and (2) the restriction on use of a telephone for furnishing telehealth services (in § 410.78(a)(3)), but only if the telephone has audio and video capabilities that are used for two-way, real-time interactive communication.

Q: Has the place of service for telehealth changed for all services or just the new “non-traditional” additions?

A: ***In the interim final rule, CMS instructs physicians reporting telehealth services to include the place of service in which the service would normally be provided, along with modifier -95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system). This will allow for higher reimbursement, given that a significant portion of services are being provided via telehealth due to the public health emergency.***

Q: Has the frequency limit on virtual visits and telephone calls been lifted? The interim final rule lists a number of telehealth services in which the frequency limit has been waived.

A: ***CMS says: 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)

Q: Is CMS now allowing 90000-series CPT codes for virtual visits instead of HCPCS codes G2010-G2012?

A: ***CMS is allowing separate payment for CPT codes 99241-99243, 99441-99443, and 98966-98968 in addition to HCPCS codes G2010-G2012, on an interim basis for the duration of the public health emergency, according to the interim final rule.***

Q: Is modifier -GQ (via asynchronous telecommunications system) specific for only Alaska and Hawaii?

A: ***Yes. When you append modifier -GQ modifier, you are certifying the asynchronous medical file was collected and transmitted to you at the distant site from a federal telemedicine demonstration project conducted in Alaska or Hawaii.***

Q: Can we report CPT code 99211 (office or other outpatient visit for the E/M of an established patient, that may not require the presence of a physician or other qualified healthcare professional. Usually, the presenting problem[s] are minimal. Typically, 5 minutes are spent performing or supervising these services) when performed by an RN?

A: ***Without knowing your specific scenario, I can only say that 99211 may be reported as a nurse visit, so long as the RN is working under scope of practice, within state licensure requirements, and under required supervision.***

Q: How does CMS define a patient initiating a telehealth service? Does the patient need to call the office? What if the patient was initially scheduled for an in-office visit, but the staff calls to offer a telemedicine appointment?

A: ***My interpretation is that the patient must initiate the healthcare service (e.g., had an appointment, is requesting the appointment). Providers can encourage patient to use the service; however, if the patient does not agree, then the service should not be billed as telehealth.***

Q: Telehealth is not allowed if the patient and provider are located in the same facility, correct?

A: ***At this time, CMS directions indicate that is correct.***

Q: We may do a telehealth virtual visit at a time we're not in the office. Do we need to then register the patient? If not, when do we need to register the patient?

A: ***CMS has not yet provided guidance on patient registration. However, if telehealth takes place after hours, the practitioner should create the addendum/note in the patient's record (dependent upon practitioner permissions in the electronic health record). The patient can be registered after telehealth service is provided. The registration should be completed promptly.***

Q: Is CMS' Accelerated and Advance Payment Program for providers determined by individual or group National Provider Identifier (NPI)?

A: ***Consult with your Medicare Administrative Contractor (MAC) for details on the program. One MAC said:***

The Provider Transaction Access Number (PTAN) and NPI combination submitted on the request form should represent the PTAN and NPI that receives payment. Example: If an individual PTAN and NPI are reassigned to a billing group, the PTAN and NPI for the billing group should be submitted. This means that a performing provider who is paid under a billing group can't submit a request for an advance payment. The request must be submitted by their billing group.

Note: The Accelerated and Advanced Payment program has been suspended. In light of the $175 billion recently appropriated for healthcare provider relief payments, on April 26, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately. Beginning on April 26, 2020, CMS is not accepting any new applications for the Advance Payment Program, and CMS will be reevaluating all pending and new applications for Accelerated Payments in light of direct payments made available through HHS's Provider Relief Fund. Significant additional funding will continue to be available to hospitals and other healthcare providers through other programs.

Q: Should modifier -95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) be used on both telephone calls and video visits for all payers?

A: ***CMS is asking providers to report modifier -95. Commercial insurances may differ. Therefore, it is recommended you reach out to your commercial insurance carriers.***

Q: Are hospitals able to bill for the specimen collection HCPCS codes such as G2023 (specimen collection for SARS-COV-2, coronavirus disease [COVID-19], any specimen source)?

A: ***HCPCS codes G2023 and G2024 (specimen collection for SARS-COV-2, coronavirus disease [COVID-19], from an individual in a SNF or by a laboratory on behalf of a HHA, any specimen source) are to be reported by Medicare-enrolled independent laboratories and are not to be reported by hospital laboratories.***

The interim final rule (CMS-5531-IFC) established HCPCS code C9803 (hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus2 [SARS-COV-2] [coronavirus disease (COVID-19)], any specimen source), a new E/M code solely to support COVID-19 testing during the public health emergency. HCPCS code C9803 allows hospitals to bill for specimen collection. The code is a conditionally packaged service under the OPPS. C9803 will receive separate payment when it is billed without another primary covered hospital outpatient service.

Q: I was under the impression that modifier -95 (synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system) is for non-Medicare payers and that we need to use place of service code 02 (telehealth) to report telehealth services to Medicare. Is this correct?

A: ***This was correct prior to the public health emergency (PHE). Under the PHE, CMS is requesting the use of modifier -95 and reporting the place of service as though the service was provided in person or face to face. See the interim final rule for more information.***

Information current as of April 5, 2020