Society for Maternal-Fetal Medicine

Coding Committee

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SMFM Coding White Paper: Interim Coding Guidance: Coding for Telemedicine and Remote Patient Monitoring Services during the COVID-19 Pandemic

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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/tips/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/c4ccb382b8428d22cbcb2c5dd560633f-original.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.

Here we provide basic targeted guidance and address the most important issues on telemedicine and remote patient monitoring services for our membership to be able to more readily and rapidly start using this modality. It is out of the scope of this document to provide every detail on telemedicine in MFM. Physicians must ensure that they meet many safeguards before providing services, including conforming with local, state, and federal regulatory laws and licensure requirements. Insurance carriers should provide clear guidelines to ensure health insurance coverage for telemedicine encounters. Telehealth provides technology-enhanced health care delivery opportunities that enhance, not replace, the current standard of care. Given the rapid and ongoing changes of the COVID-19 Public Health Emergency, coding guidance provided here may be subject to change or obsolete at a later date and/or once the state of emergency resolves.

Types of Telehealth

Telehealth refers to a broader scope of remote services than telemedicine and is a collection of means or methods for enhancing health care or health education using telecommunications technologies. Telehealth services comprise 3 components- clinical care, technology support, and administration. Telemedicine is the delivery of medical care or services from a distant site and involves real-time interactive audiovisual communication between a patient and healthcare provider. Types of telehealth modalities include:

- *Live, two-way or real-time synchronous audio and video*: Provider and patient communicate in real-time to discuss conditions but not in the same location. Audio/video must include broadband speeds sufficiently fast enough to enable conversations as if they were in the same room.
- *Store-and-forward, aka asynchronous telemedicine*: Information (eg, ultrasound recordings) is captured from patient at one time and location, and evaluated by a provider at another time and location.
- *Hybrid consultation:* Blends synchronous and store-and-forward modalities.
- *Remote patient monitoring (RPM):* Collects personal health and medical data (eg, blood glucose, blood pressure) from one location and electronically transmits the data using medically designated devices or smartphone applications to a physician in a different location for use in clinical care.

Services may be rendered by a membership organization or independent businesses.

Benefits of telehealth

Telehealth increases access to specialty care in regions (eg, quarantined areas) that would otherwise lack in this specific area of care, improves efficiency, enhances provider delivery, extends the scope of obstetric practice, could improve pregnancy outcomes, reduces costs in the healthcare system, reduces travel burden and related costs to the patient, increases patient satisfaction and convenience, among others.

Telemedicine can be used in many settings such as provider to provider consultation, provider to patient consultation, ultrasound or fetal echocardiogram, antenatal testing, remote patient monitoring (blood pressure checks, diabetic management), postpartum treatment (depression, weight loss, follow-up), research, and patient education.

Telemedicine is also crucial in disaster relief and has played a historical role such as in Hurricanes. When a disaster occurs, healthcare resources are limited and need to be immediately pulled in order to provide wider access to both emergent and non-emergent care, which can be better achieved by the implementation of telemedicine.

Requirements and important issues for providing telemedicine services

Telemedicine services are live videoconference consultations where a physician and the patient communicate in real-time **face-to-face** but are not in the same geographic location. Typically, the specialist is in their office or a medical facility, defined by Medicare as the **distant site**. The patient is at a different location (eg, a clinic or hospital) and may be accompanied by her local provider or a telemedicine facilitator at that location, defined as the **originating site**. Communication is facilitated by using secure high-speed videoconferencing allowing for synchronous, real-time provider-to-patient interaction. Telemedicine endeavors may range from single originating and distant sites to networks comprising many sites, delivering any number of maternal-fetal

medicine services. In most cases, you may build the team using existing clinical, administrative and technology staff members. Basic team members include physician(s), sonographer(s) providing tele-ultrasound (if applicable), IT personnel (both sites), and scheduler/coordinator. You may need additional training or scheduling template changes in order to incorporate telemedicine consultation into daily practice. There are a number of important requirements for set up. Here we share basic needs.

- *Equipment*: Ensure your telemedicine network has necessary secure hardware and software to provide reliable connections with secure and sufficient bandwidth to support real-time interaction between originating and distant sites. Adequate camera, speakers, microphone, and sufficient processor speed are key. Be aware of federal and state-specific telehealth network, connectivity, and equipment rules to ensure effective, safe, and reimbursable service. Conduct a mock visit(s) before live implementation. A variety of qualified commercial telemedicine platforms exist; the Society for Maternal Fetal Medicine Coding Committee does not endorse any specific vendor for telemedicine resources. Physicians should teleconference in a quiet professional environment and dedicate time specifically for video conferencing patients, as if the patient were physically present. Telemedicine patients should receive the same level of care and treatment guidelines as for in-person visits.
- *State Medical Board requirements, Licensure*: Individual state medical boards have many rules related to tele-health. Physicians providing telemedicine should be aware of those rules for all states they will practice telemedicine in. Physicians must hold a license in the state where the patient is located (few if any state exceptions may apply; some states have reciprocity programs to expedite licensure).
- *Malpractice Insurance*: Ensure coverage for a telehealth policy from your medical liability carrier and that the coverage extends to other states, if applicable. Physicians should request proof in writing of such policy with any limitations or restrictions noted explicitly.
- *Credentialing and Privileging:* Check whether the facility where the patient is located requires the physician to obtain privileges (alternatively, some hospitals may allow "privilege by proxy"). Likewise, the physician should hold privileges for telehealth in their own institution. Check with local State officials if the patient can be contacted using appropriate equipment, while at home.
- *Reimbursement:* Check with insurance companies and the CMS to understand your local telehealth coverage policies. Insurance carriers should provide clear guidelines to ensure appropriate coverage for telemedicine encounters. (As noted, CMS has relaxed guidelines in setting of the COVID-19 Public Health Emergency specifically for Medicare beneficiaries; discussed later).
- *Security:* Physicians who provide telehealth must comply with HIPPA privacy, network encryption, and other security precautions. Patients should be counseled on limitations of privacy and security in the realm of telemedicine; even the most secure set up may be vulnerable to unauthorized access.
- *Integration of EMR:* Electronic Medical Records (EMR) can be customized and integrated based on individual site needs and set ups.
- *Know the law:* Physicians providing telehealth should be knowledgeable on state-specific and federal laws regarding telehealth credentialing, reimbursement, and other relevant issues.

Billing and Payment

Telemedicine consultations require the same elements as those required in regular face-to-face consultations: (1) Request for consultation; (2) Opinion; (3) Written Report.

In 2017, CPT published a set of procedural codes for services that can be performed using a live, synchronous platform (Appendix P). From this set, currently relevant CPT codes for maternal-fetal medicine subspecialists would include the following E/M series: 99201-99215 office outpatient, 99241-99245 outpatient consultation, 99212-99215 outpatient follow up, 99251-99255 initial inpatient, and 99231-99233 subsequent inpatient. *Please recall that CMS/Medicare and several other payers still do not recognize or accept consultation codes, and we do not anticipate that this would change during a public health emergency.*

CPT 96040 Genetic Counseling (time-based, face-to-face time) is also in the CPT set of codes that can be performed via telemedicine; however please note that this code is only to be used by qualified, certified and credentialed genetic counselors who are already contracted and approved with specific payors for reimbursement using this CPT and that genetic counseling for pregnancy management may not be covered under all plans. Please have your genetic counselors confirm with individual payers. This code is not for use by physicians; physicians providing genetic counseling services face-to-face would bill appropriate time-based E/M codes.

The communication of information exchanged during the course of the synchronous telemedicine service must be sufficient to meet the same key components and/or requirements of the CPT when rendered face-to-face with patients; with regards to telemedicine, this would namely be total time spent face-to-face with the patient and (>50%) in counseling and coordination of care and must be clearly documented in the written report. In order to bill for these services, Place of Service (POS) Code 2 is used to specify the entity where services were rendered. POS 2: The location where health services and health related services are provided or received, through a telecommunication system. In addition, Modifier -95 is appended to the appropriate E/M CPT code. Modifier -95 Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System. Some managed care and other plans may require additional modifiers. In addition, Modifier -25 is applicable when significant, separately identifiable evaluation and management service is performed by the same physician on the same day of a procedure or other service (eg, ultrasound).

Check with individual payers for reimbursement policies regarding these codes (as well as any alternative or additional codes they may request to be used). Please also consult with your biller to ensure these recommendations are followed. Patients remain responsible for co-pay, deductible, and co-insurance patient share fees per their individual plans.

Prior to the CMS emergently broadening access and liberalizing telemedicine rules on March 17, 2020, there were several Federal payer restrictions for telemedicine services. Some of the restrictions are discussed here. Approved originating sites must be outside of a metropolitan statistical area or in a rural health professional shortage area and included physician offices, hospitals, critical access hospital, rural health clinics, and federally qualified health centers. As noted, earlier, please check with your State and Local Payers, as even prior to the COVID-19 public health emergency, some commercial payers do not have restrictions on originating site; the patient can be home for instance. Requests for consultation need to come from the originating site via a medical provider. Both the originating site and distant site have to be approved to provide telehealth service to avoid claim denial. Prior authorization may be required in order to bill for telehealth services at both the originating and distant sites. Once the initial encounter is established in person, a follow-up encounter can then be established via telemedicine or with an in-person consultation. The patient has the option to decline telemedicine at any time and request an in-person encounter. Use of a HIPPA compliant platform is crucial.

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

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.***

For more information on HIPPA compliance during the national emergency, please see the Office of Civil Rights Notification at the following link. (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html?fbclid=IwAR0I-XO4DQ9vR9VvAF7auJUie_KQkpPX7Uxq_NKo-o7V3dHxZXQJoVLfvqY). A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. As noted, Facebook Live and similar video communication applications that are public facing, should not be used in the provision of telehealth. Lastly, 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.

Additional codes/information:

Online Digital Evaluation and Management (99421 – 99423; 98970 – 98972)
Online services are new 2020 time-based CPT codes for online evaluation and treatment which may be of clinical utility during this public health emergency by a physician or other qualified health care professional.

Physician/Advanced Practitioner Services (Established Patient):

99421 5-10 minutes
99422 11-20 minutes
99423 21 or more minutes

Non-physician Services (Established Patient):

98970 5-10 minutes
98971 11-20 minutes
98972 21 or more minutes

It is unclear at this time whether the established patient rule, or the requirement that the patient initiate these services will be waived during the COVID-19 Public Health Emergency.

- Includes review, assessment, interaction with other clinical staff, management plan, and communication with patient (in HIPAA-compliant platform)
- Services must be initiated by the patient
- Bill once for cumulative time during a 7-day period
- Time includes work of all providers in the same group
- Cannot bill if separately reportable E/M occurs within 7 days after completing digital E/M
- Cannot bill if separately reportable E/M **for the same/related problem** occurs within 7 days before digital E/M
- Do not bill if digital E/M is within the post-op period of a procedure

Documentation

- Clearly identify services as non-face-to-face online/digital E/M
- Location of the provider and the patient should be documented
- Document all activities for the 7-day reporting period
- Time must be documented
- For physician/QHP services, do not include other staff time
- Document discussion with patient
- Verify and document patient understanding of plan and instructions
- Document any referrals and orders
- All entries related to the service must be signed and dated

Telephone (Audio-Only) Services (99441 – 99443; 98966 – 98968)

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

It is unclear at this time whether the established patient rule, or the requirement that the patient initiate these services will be waived during the COVID-19 Public Health Emergency.

- 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
- 99441-99443 are for physician and APN services. 98966-98968 are used for non-physician clinical staff.

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

Remote Physiological Monitoring Treatment Management Services (99457, 99458)

New CPT codes became available in 2019 to provide additional opportunities for remote monitoring of patient health data and reimbursement. These new codes involve using a device to track a patient's important health metrics, such as blood glucose or blood pressure. These services are distinct from telehealth services and do not require face-to-face interaction though patients are expected to be established patients seen by the practitioner face-to-face within one year prior. Patient cost-sharing such as deductibles, co-payments, co-insurance still apply. Remote physiological monitoring treatment management services are provided when clinical staff, physician, and or other qualified health care professional use the results of remote physiological monitoring to manage a patient under a specific treatment plan.

To report remote physiological monitoring, the device used must be a medical device as defined by FDA, and the service must be ordered by a physician or other qualified health care professional. CPT codes 99457, 99458 require a live, interactive communication with patient/caregiver. (Do not count any time on a day when the physician or other qualified health care professional reports E&M service - office or other outpatient services, inpatient services, rest home services, or home services.)

99457: Remote physiological monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes. The code can be reported once in 30 days, regardless of the number of parameters monitored. Cannot be reported for services of less than 20 minutes

99458: Each additional 20 minutes. Must be listed separately and reported in conjunction with 99457.

Conclusions

Coding guidance will continue to change and evolve during this time. Telehealth and remote patient monitoring services are essential and beneficial tools for providing care to pregnant woman during the COVID-19 Public Health Emergency.

Example Scenarios

1. Sarah is a 37yo G1, 17 weeks GA, quarantined at home during the COVID-19 pandemic. All ultrasounds to date have been normal. However, she was seen in the office by her OB Dr. Jones and MSAFP screen came back positive. Sarah would like more information about the meaning of the abnormal results and risks/benefits of further testing. Dr. Jones sends a consultation request to the patient's MFM Dr. McCain. Dr. McCain sees her face-to-face via telemedicine, counsels and answers her questions. Dr. McCain documents the content of the counseling and notes that the total encounter was 40 minutes and 100% of the time was spent in counseling and coordination of care. Sarah has her questions answered and avoids needing to come to the office. Recommended coding: POS 2, 99243-95.

2. Olive is a 29yo G3P2, 34 weeks pregnant, with GDMA1, quarantined at home during the COVID-19 pandemic. She was seen in the MFM office last week for evaluation and ultrasound and was doing well. All ultrasounds have been normal to date. She saw her OB earlier this week. She lives in a rural area. Since seeing MFM last week, she has had several elevated blood sugars and wants to discuss what she should do. Her OB is requesting a consultation with MFM Dr. Stevenson.

a) *Dr. Stevenson has face-to-face video capability*
   Dr. Stevenson sees her face-to-face via telemedicine and answers her questions and discusses insulin treatment if her blood glucose control does not improve. He documents the content of the counseling and notes that total encounter face to face time was 25 minutes and 100% was spent in counseling and coordination of care. Olive is satisfied she did not have to leave her home quarantine for this visit. Recommended coding: POS 2, 99214-95.

b) *Dr. Stevenson only has telephone services (audio only)*
   Dr. Stevenson calls Olive and reviews her blood sugars over the phone. He discusses option for treatment including oral hypoglycemics or insulin management if blood glucose control does not improve. He documents the content of the counseling and notes that total time was 10 minutes. Recommended coding: It is unclear if during the COVID-19 outbreak, these sorts of scenarios will be allowed to be billed via telephone (audio) only codes. If payers allow this coding would be 99441.

Please submit any questions you may have to the SMFM Coding Committee Ask a Coding Question website (https://www.smfm.org/coding/questions/new). Additional information and resources are also available on our coding website. Thank you very much.