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Coding in the World of COVID-19: Non-Face-to-Face Evaluation and
Management Care

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ABSTRACT

Almost all medical care in the United States is delivered with the provider and patient in immediate proximity; this model is referred to as *face-to-face care*. Medical services can be apportioned as procedural care (eg, surgery, radiology, or laboratory testing and others), or cognitive care, also known as Evaluation and Management (E/M) services, in which the provider formulates an assessment and plan after obtaining information from the patient's history, examination, and diagnostic tests. Providing a medical opinion and plan using the telephone as the technology that links the provider and the patient is an example of a *non-face-to-face* E/M service. *Common Procedural Terminology (CPT)* codes and the details for how to provide telephone services have been available for decades but have not been reimbursed and therefore were rarely used. In recent years, as new technologies have evolved, there has been slow and steady acceptance that non-face-to-face E/M care can be an adjunct to or replacement for some face-to-face E/M services. These technologies and the descriptors for associated *CPT* and Healthcare Common Procedure Coding System (HCPCS) codes were introduced over the past few years and have become known by the generic term *telehealth*. They have been slowly incorporated into medical practice. Most of these services were introduced in the consumer retail market, in which the cost was borne directly by the patient, or as private contract services, in which the cost was borne by the consulting hospital, such as with telestroke services. In both the

consumer retail model and private contract model, the care delivered usually did not involve *CPT* or HCPCS coding. The adoption of telehealth has been slow, in part because of the initial costs and several regulatory constraints, as well as the reluctance of patients, providers, and the insurance industry to change the concept that medical care could only be delivered when the patient and their provider were in physical proximity. After the COVID-19 pandemic reached the United States, the US Department of Health & Human Services issued a public health emergency and declared a Section 1135 Waiver that lifted many of the administrative constraints. With the need for near-absolute social distancing, this perfect storm has resulted in the immediate adoption of telemedicine, at least for the duration of the pandemic, for cognitive care to be delivered using communication technologies that are already in place. This article discusses the most common forms of non-face-to-face E/M care and the proper coding elements necessary to provide these services.

INTRODUCTION

In late 2019, an outbreak of illness caused by a novel coronavirus called *SARS-CoV-2* was identified and labeled *COVID-19*. Initially the virus caused an epidemic, but in March 2020, the World Health Organization (WHO) declared the illness a pandemic. Within weeks of first appearing in the United States, the national societal structure began to change as social distancing became the most potent method of dealing with the spread of the illness. The first response made by many large health care institutions was to restrict nonessential business travel as a way to protect their medical staff from illness, and, within a week, they began canceling nonurgent surgical cases to add bed capacity for the expected influx of patients ill with COVID-19, and then nonurgent medical appointments to protect both the patients and medical staff.

Although patients in urgent need for medical care continued to be seen in the office setting, a need existed for physicians to provide care by an alternative means for both new and established patients, and the use of remote services escalated from a slow rollout to a “need it now” priority. In the face of the COVID-19 public health emergency and what may be months of mandated social distancing, the US national payer network (the Centers for Medicare & Medicaid Services [CMS], state Medicaid, and private payers) and state health agencies are helping to ensure patients get the care they need by enabling providers to be reimbursed for non–face-to-face services.

Neurologists traditionally have provided face-to-face patient care captured by *Current Procedural Terminology (CPT)* Evaluation and Management (E/M) codes that require documentation of certain elements of the history, physical examination, and medical decision making.¹ Medical decision making is the cognitive work performed by providers that integrates their knowledge and experience with the patient’s history, physical examination, laboratory results, and other data to formulate an assessment and plan. CMS defines medical decision making as a measure of work intensity that is based on the number of diagnostic and management options considered; the complexity of data analyzed; and the risk of complications, morbidity, and mortality associated with the presenting problem(s) and subsequently with the procedures and management options for the problem(s).

The vast majority of these visits consist of outpatient new patient visits (*CPT* codes 99201 through 99205), outpatient consultations (codes 99241 through 99245), and outpatient established patient visits (codes 99212 through 99215). Codes are also available for hospitalized patients, including new admissions (codes 99221 through 99223), inpatient consultations (codes 99251 through 99255), subsequent hospital care visits (codes 99231 through 99233), and

discharge day planning (code 99238 or 99239). E/M codes have also been established for critical care, emergency care, domicile care, and other visit types. These E/M codes have been the backbone of American medicine for decades and represent more than 60% of the work performed by neurologists. The key criterion allowing use of most of these codes has been the requirement for a face-to-face encounter.

Over the past decade, physicians, payers, and patients have been interested in transitioning some care from the traditional face-to-face care to remote care that is made possible by communication technologies. Although some non-face-to-face care uses advanced digital technologies, the most ubiquitous communication technology is the telephone. *CPT* codes for telephone encounters have existed for decades, but payers have declined to reimburse providers for this service. Even before the COVID-19 public health emergency, many patients were unable to obtain optimal care because they could not travel to the physician, whether because of their illness, excessive distance, or social barriers. Non-face-to-face care is needed or even obligatory when easily accessible specialty expertise is lacking, especially on an emergency basis. Geographic separation of patients from physicians is exacerbated by poor access to transportation and patients with poor mobility. This is a problem not only in rural settings but also in congested urban environments.

For patients, a major advantage of remote visits using communication technology is the decreased time away from work or child or elder care resulting from eliminating the time needed for travel to the doctor's office, parking their vehicle, and waiting for the appointment. In the face of COVID-19, these advantages are even more pronounced. The most obvious disadvantage of remote visits for providers is the difficulty of performing the clinically indicated examination. In some models of remote care, another provider or medical professional is in the same room as

the patient and assists in the examination. Even without another medical professional physically available to assist with the patient examination, tools and techniques can be put in place to assist with the neurologic examination; however, not all patient visits can be properly or completely handled with remote or telemedicine visits.

Historically, all non–face-to-face care had to be performed on established patients. Non–face-to-face *CPT* and corresponding and complementary G codes developed by CMS have been introduced in recent years to make remote care available to more patients. This trend has been greatly accelerated in response to the immediate health care needs associated with the COVID-19 public health emergency.

In view of very restrictive payer policies, much of the telemedicine provided until very recently has been based on a consumer retail or private contract model. In the consumer retail model, remote care is paid for by the patient at the time of service or funded by preexisting contracts set up by the patient’s insurance company with the health care system providing the remote access. In the private contract model, large medical systems, companies focused on providing telemedicine services, and independent doctors typically engage in contracts with small or rural hospitals in need of telemedicine services. The most common service is the remote evaluation of patients with possible strokes who may be within the window for intervention, called *telestroke*. In addition to telestroke, neurologic services are available that can provide remote evaluations for diverse neurologic problems (known as *teleneurology*). In general, the service is contracted on a per-use basis or monthly maintenance plan. In both these models, since insurers are not involved, compliance with payer-mandated documentation and coding policies is not needed. Until the COVID-19 public health emergency, the implementation rate of telemedicine services

was leisurely, but that has changed almost overnight because of the dramatically relaxed restrictions on the use of non–face-to-face services.

Because the widespread use of these codes is new, it is imperative that neurologists check with their malpractice insurance carriers to ensure their policies cover providing telemedicine care and ensure their hospital privileges include telemedicine care. Clinicians must also familiarize themselves with payment and policy guidelines specific to various telemedicine services and work within the framework set by federal and state governments, national regulatory bodies, and their employers' information technology and compliance policies. The American Academy of Neurology (AAN) has developed guidance for clinicians and practices planning to implement telemedicine services amid the COVID-19 public health emergency, and a link to the Telemedicine and COVID-19 Implementation Guide² is included in the Useful Websites section below. The AAN also has a Telemedicine and Remote Care resources page (aan.com/telehealth) and a general resource center for all information related to COVID-19 (aan.com/COVID19). Regulations discussed in the AAN Telemedicine and COVID-19 Implementation Guide have an effective date of March 6, 2020, and are in effect for the duration of the public health emergency as determined by the US Department of Health & Human Services (HHS). Because of the unique nature of a public health emergency, some guidance and information in this article may not align with the AAN's overall telemedicine position, which was created before the current crisis. This article outlines the current non–face-to-face E/M codes for single patient encounters. Although both *CPT* codes and G codes are created for the entire network of US-based medical care, each insurance carrier decides which codes are reimbursed and under what conditions. In addition, the individual state's Department of Health regulates how certain aspects of medical

care are delivered, with different rules that can affect how a specific E/M service can be used in caring for patients.

NON-FACE-TO-FACE SERVICES

The provider and patient are not in direct physical proximity for any of the non-face-to-face services. A telemedicine visit can occur with the patient in the next room, but typically the patient is located miles or even several states away from the provider. The site of service is defined as the location of the patient, not the provider. The provider and patient are linked by secure electronic communication technology, which may include telephone, secure email, a portal within an electronic medical record, or other audio or video connection. These services are referred to as *telemedicine* or *telehealth*. More specific terms are also commonly used, such as *telestroke* for stroke services or *teleneurology* for neurologic services.

The most robust current model of telemedicine involves *synchronous* (or real-time) audio and video visits. Several definitions of synchronous exist as it relates to telemedicine visits, but critical elements include both patient and provider be present in real time and communicate through a live audio and video telecommunication system. An *asynchronous* encounter uses “store and forward” technology in which a question or medical data (such as a photo or video clip) is sent to the provider, who later responds with an opinion, although multiple component interactions can occur with an asynchronous encounter. Until recently, in most cases of synchronous visits using audio and video telecommunication systems, the patient was colocated with the consulting physician or other health care professional, while the consultant provider was on the other end. A typical example is a patient and maternal-fetal medicine physician on one end and a genetic counselor or child neurologist acting as the consultant on the other end;

another example is the patient and emergency department physician on one end and the stroke neurologist on the other end serving as the consultant.

Until the 2020 COVID-19 pandemic, state medical licensure regulations limited some telehealth services that crossed state lines and included requirements for end-to-end Health Insurance Portability and Accountability Act (HIPAA)–compliant hardware and software. In early March 2020, the HHS issued the Section 1135 Waiver and CMS issued a blanket waiver of health care laws in response to the COVID-19 public health emergency.³ Many states followed the HHS and CMS and loosened regulations that were in place for many years. Many of these rules literally changed overnight. Because these rules are changing quickly and may revert once the pandemic resolves, it is imperative to remain informed. HHS recently waived the need for a provider to have a medical license in the state where the patient is located, although implementation of this part of the regulation requires approval from the states, as well as the requirement for use of HIPAA-compliant platforms. Before the public health emergency, telemedicine services typically could be provided to established patients, defined by CMS as a patient seen by the provider or a member of the provider’s specialty and practice within the previous 3 years. Although *CPT* codes existed for synchronous telemedicine services using a real-time interactive audio and visual telecommunication system for new patients, they were not reimbursed. At the time of publication, these services will be covered for both new and established outpatient visits and established inpatient visits, although as providers are quickly trying to adapt, all payers are interpreting these changes, updating coverage policies, and changing their computer billing codes to adopt these new regulations. For several months following the implementation of these new regulations, provider billing offices will need to monitor payments and automated rejections.

Several different types of non–face-to-face E/M services exist. Many of these services are defined by a brief epoch of care for the E/M service, including elements of history, examination, and medical decision making. They are distinct from non–face-to-face codes such as chronic care management, transitional care management, care plan oversight, and coagulation management types of care, in which the care is prolonged and includes management but not necessarily patient evaluation.

Several distinct features distinguish these non–face-to-face E/M codes, including the specific technology required, whether the care is synchronous or asynchronous, whether the care is delivered in one session (generally a minimum of 5 minutes up to the duration of a typical office visit) or over a period of time (such as 7 days), and whether or not video is required. Various proprietary platforms are available for telemedicine but are beyond the scope of this article.

Telephone Services

The full descriptions of *CPT* codes 99441, 99442, and 99443 for telephone services are as follows:

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

99442 11-20 minutes of medical discussion

99443 21-30 minutes of medical discussion

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Telephone services are non–face-to-face E/M services provided to a patient by a physician (or other qualified health care professional who may report E/M services) using the telephone. These codes are used to report episodes of patient care initiated by an established patient or parent or guardian of an established patient. If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather, the encounter is considered part of the preservice work of the subsequent E/M service, procedure, and visit. Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous 7 days (either requested by the patient or unsolicited patient follow-up) or within the postoperative period of a previously completed procedure, then the service(s) is (are) considered part of the previous E/M service or procedure. Codes 99441 through 99443 should not be used if code 99421, 99422, or 99423 has been reported by the same provider in the previous 7 days for the same problem.

As a practical consideration, drawbacks exist in using the telephone consultation codes. The provider must spend a minimum of 5 minutes participating in the phone call and then document the interaction for the lowest level of the telephone encounter service to submit a charge.

Furthermore, billing software typically involves a process of creating an encounter that may include an administrative step requiring some form of registration and insurance verification, which may add a greater administrative burden than the practice can handle. For patients who may require 10 or more minutes of provider time and if a synchronous telemedicine service rendered via a real-time interactive audio and video telecommunication system can be performed, the patient’s needs may be better served with the latter service. Each practice should evaluate its own workflow to determine if the volume of phone calls lasting more than 5 minutes

is worth the added workload created to fulfill the requirements necessary to complete this procedure.

Virtual Check-ins

The G codes represent a different code set known as the Healthcare Common Procedure Coding System (HCPCS), which is maintained by CMS.⁴ Codes G2012 and G2010 describe services designated by CMS as virtual check-ins. The full descriptions of G codes 2012 and 2010 are as follows:

G2012 Brief communication technology-based service, eg, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.

G2010 Remote evaluation of recorded video and/or images submitted by an established patient (eg, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.

G2012 is analogous to 99441 (the *CPT* code for a 5- to 10-minute telephone encounter) and is defined as a “brief communication technology-based service” that allows communication by way of telephone or other electronic device, including video exchange, for established patients. Major procedural components for this code include that the specific technology would most often be the telephone, that the interaction is synchronous and generally occurs in one session, and that video is not required. This must be a patient-initiated service, and, because Medicare coinsurance and

deductibles apply, the patient must give verbal consent to these services. The rules regarding timing of the call related to prior or future office visits are the same for G2012 as they are for CPT codes 99441 through 99443. No G codes define the work for longer telephone encounters. G2010 is reported for the remote evaluation of recorded video and/or images submitted by an established patient (eg, “store and forward”). It has the same requirements as G2012 regarding timing of the service in relation to prior or future office visits. Typically, the practitioner looks at the image or video and subsequent communication by the practitioner or other clinical staff with the patient takes place. Follow-up with the patient in an at least 5-minute response is required, which can be in the form of a telephone discussion, audio-video communication, secure text message, email, or patient portal communication. If the image received is insufficient to make a determination or medical impression, G2010 cannot be billed. Patient consent (verbal, written, or electronic) is required, and the charge will be subject to coinsurance and deductible. This service can only be provided to an established patient.

Case 1

A 60-year-old woman with a history of stable chronic obstructive pulmonary disease, hypertension, and well-controlled seizures presented to her primary care physician with a painful facial rash. Her only flurry of seizures had occurred 7 years ago, which resulted in the discovery of a benign meningioma that was treated with surgical resection; she was being followed annually for any seizure recurrence. She remained on oxcarbazepine 600 mg 2 times a day as personal preference, although she had not had a seizure since her surgery. Her last MRI and office visit were 2 months earlier, and the MRI showed no evidence of recurrence of the tumor. The primary care physician diagnosed her with shingles but did not feel comfortable prescribing

pain medications in the face of ongoing oxcarbazepine therapy and referred her for a neurologic consultation by telephone.

During the phone call, a medication, allergy, and problem list reconciliation was performed. A brief review of systems and medical history was taken and uncovered no new issues other than the pain, which the patient rated as a 6 on a 1 to 10 scale. The patient took her temperature and was not febrile and otherwise felt fine. Because of COVID-19 concerns, neither the patient nor primary care physician thought an office visit was necessary if the neurologist prescribed medication.

The neurologist recommended gabapentin and discussed the dosing, expectations for improvement, potential side effects, and recommendations for phone or office visit follow-up. During the phone encounter, the neurologist electronically sent the prescription to the patient's pharmacy. The total duration of the phone call was 17 minutes.

Discussion. The recommended code for this service is 99442, telephone service with 11 to 20 minutes of medical discussion. If the patient was 66 years old and covered by Medicare, the correct code to choose would be G2012. Although the phone call was in excess of 10 minutes, no high-level G code codes area available for longer telephone calls. As of March 6, 2020, and for the duration of the COVID-19 public health emergency, this code will be reimbursed for all Medicare patients in all areas of the country.⁵ Some third-party payers have adopted the G2012 code and not *CPT* codes 99441 through 99443, as the single G code is easier to audit and less costly than the *CPT* codes for the same type of service.

Online Digital Evaluation and Management Services

The full descriptions *CPT* codes 99421, 99422, and 99423 for online digital E/M services are as follows:

99421 Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes

99422 11-20 minutes

99423 21 or more minutes

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As with telephone encounters, online digital E/M services must be initiated by the patient or guardian. The technology necessary requires a HIPAA-compliant platform such as an electronic health record portal, secure email, or other digital applications, with the clinician, although for the duration of the COVID-19 outbreak, the HIPAA-compliant requirement has been lifted. The interaction is most often asynchronous but could be synchronous, and attachments are not required but sometimes can be helpful, such as in viewing a brief video of an abnormal movement or a photograph of a cutaneous drug reaction. The code is time based, and total time is determined by the cumulative provider time spent performing the elements of E/M during a period of up to 7 days. The elements of E/M are similar to an office visit, but no specific elements are required, although it is difficult to conceive that the encounter will not contain some degree of history and medical decision making. The communication can be a single exchange or consist of several back-and-forth interactions that occur over a period lasting up to 7 days. Executing the plan, such as writing prescriptions or placing orders during the exchange of information between the patient and clinician, is considered part of the total time, which is not

true for telephone encounters. All documentation must be saved either electronically or as a hard copy. As with telephone encounter codes, this code cannot be used within the 7 days after a face-to-face E/M service if related to the same complaint. If the online digital E/M service results in a face-to-face visit within 7 days after the initiation of the service, the time spent and data accumulated can be incorporated into that face-to-face E/M visit, but an online digital E/M service code cannot be submitted. Codes 99421 through 99423 also cannot be used in the same month during which the patient is receiving care plan oversight services (codes 99339 and 99340), coagulation management services (codes 93792 and 93793), chronic care management services (codes 99487 through 99489), or transitional care management services (codes 99495 and 99496).

Corresponding codes with the same rules and time requirements are used if the communication occurs with a qualified nonphysician health care professional (eg, a registered nurse): 98970 (5-10 minutes), 98971 (11-20 minutes), and 98972 (>20 minutes).

Clinicians must keep track of time, as time less than 5 minutes cannot result in submission of any charge. As with the telephone codes, a mechanism that will allow the clinician to submit the proper code at the close of the encounter is needed.

Case 2

A 66-year-old man with Parkinson disease had been cared for by a neurologist for over a year. The neurologist had prescribed carbidopa/levodopa 25/100 mg 3 times a day, which resulted in a vast improvement of the patient's bradykinesia. During the prior month, the patient and his family had noticed the effects of the medication seemed to be wearing off before the next dose was due. The patient notified the neurologist of this through the portal in his electronic medical

record. He attached a 15-second video clip filmed by his wife immediately before his 8 PM dose that demonstrated severe bradykinesia and a second video clip filmed an hour after his 8 PM dose that showed resolution of the bradykinesia. After viewing the medical record, patient's written concern, and video clips, the neurologist placed a telephone call with the patient and, over the next 7 minutes, outlined options for treatment. The patient and neurologist decided the best option for him would be to decrease the time interval between dosages.

Discussion. The recommended code for this service is G2010. The service was performed on an established patient not seen within the past 7 days, the encounter did not result in a face-to-face Evaluation and Management (E/M) service, and it consisted of a digital exchange of health care data resulting in medical decision making. If the patient was 55 years of age, the best code would be 99421, for online digital E/M services for an established patient with the cumulative time of being between 5 and 10 minutes. The major difference between G2010 and the online digital E/M services codes 99421 through 99423 is that G2010 has no higher levels.

Case 3

A 55-year-old woman with systemic lupus erythematosus and early renal impairment (creatinine 1.8 mg/dL) was being followed a neurologist for seizures that generally occurred with missed dosages of medication. The patient had been on stable dosages of belimumab, prednisone, and levetiracetam 500 mg 2 times a day. Because levetiracetam is cleared through the kidneys, her management had included monitoring of both creatinine and levetiracetam levels, which had been stable for the past few years. Her primary care physician had obtained a new creatinine value of 2.4 mg/dL and suggested the patient contact the neurologist for further suggestions on the correct dosage of levetiracetam.

The patient placed a secure electronic message through the electronic health system portal requesting the neurologist's thoughts. After the neurologist replied, asking if the patient felt fine and confirming the dosage of medications and pharmacy, and the patient responded, the neurologist electronically sent a new prescription for levetiracetam 750 mg tablets, with instructions to take half a tablet (375 mg) 2 times a day. The neurologist also sent a message to the patient letting her know the new prescription had been submitted, giving instructions, and requesting that she check in with the neurologist within this same encounter volley in 4 days. Four days later, the patient messaged that she felt fine and had experienced no seizures. The neurologist replied that she should continue the medication and get a new levetiracetam level and creatinine level taken in 3 weeks. After noting that the patient opened that reply, the neurologist closed the encounter the next day. The total time for the work was 11 minutes.

Discussion. The correct code choice for this encounter is 99422 to account for the neurologist's time spent on online digital Evaluation and Management (E/M) services. When the laboratory values are returned in 4 weeks, the neurologist will likely forward the values to the patient using the same electronic portal with a message confirming the values are acceptable or not acceptable, possibly with further instructions. Because the patient did not initiate this conversation, the neurologist cannot use code 99422. However, if the patient requests additional information and the reply from the neurologist lasts more than 5 minutes, the neurologist may use this code choice again.

Evaluation and Management Codes for Synchronous Telemedicine Services Rendered Via a Real-time Interactive Audio and Video Telecommunication System

The epitome of telehealth E/M services are patient encounters that nearly mimic the outpatient or inpatient E/M face-to-face encounters but are carried out using HIPAA-compliant audio and video equipment, with the patient and provider interacting simultaneously. The interaction between the patient and provider is instantaneous and considered a synchronous encounter. The service is formally deemed as a non-face-to-face service, yet patient and provider can make eye contact and relate in ways not possible with a telephone call, including conducting components of a physical examination. Historically, audio-video services have been used for stroke consultation in patients residing in rural areas. A faster acceptance for other types of encounters was hindered by payment policies that restricted reimbursement for patients living in metropolitan areas, although that impediment changed in 2019. Other barriers included the cost of purchasing a platform on which to conduct the encounter, the payment models for reimbursement, and reluctance based on fear of breaking the canonical concept that medical care had to be delivered in person. Because of the impact on society caused by the COVID-19, the barriers have been lifted, at least for the duration of the public health emergency.

For neurologists working in the outpatient setting, these visits would be scheduled as any office visit, and patients would be interviewed and examined (with limitations) and receive counseling and coordination of their care as if they were in the office. These visits are reported using the same E/M code that applies to the level of the face-to-face visit along with a 95 modifier (defined by *CPT* as “Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System”).¹ The E/M code choice can be made on either element-based criteria (history, examination, medical decision making) or time-based criteria

using counseling and coordination of care guidelines. CMS and select commercial plans use a GT modifier instead of the 95 modifier, which also signifies the service was provided via interactive audio and video telecommunication systems. Appendix P of the 2020 *CPT* manual¹ lists services that can be performed using telehealth technology that are reported with a 95 modifier or GT modifier and includes codes relevant to neurologists.

Most of the E/M work performed by neurologists that can use synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system include new outpatient visits (codes 99201 through 99205), outpatient consultations (codes 99241 through 99245), and established outpatient visits (codes 99212 through 99215), as well as subsequent hospital care visits (codes 99231 through 99233) and inpatient consultations (codes 99251 through 99255). Initially designed for established patients in the ambulatory rural setting, these encounters are beginning to be used for both established and new patients in the ambulatory setting and established hospitalized care. With the new rules issued by CMS in response to the COVID-19 public health emergency, these services are now available for all sites of service, including the patient's home. In addition, the new rules have eased the path for patients to receive telemedicine services in states for which the provider does not have a medical license; however, the final implementation for this change will be determined by each state. Finally, the copayment can be waived by the provider. The rules governing these services are rapidly changing to allow more telemedicine care to be delivered but could revert back to the original rules when the COVID-19 public health emergency is deemed over.

The technology for these services is typically, but not always, integrated into an electronic medical record. The requirement that the technology meet end-to-end HIPAA standards has been temporarily lifted by the HHS Section 1135 Waiver. Many platforms are available for the patient

and physician to use within the current federal laws and rules, CMS policies, and compliance standards of the provider's employer; it is incumbent upon the provider to be aware of these constraints. Currently, codes with the 95 or GT modifier are reimbursed at the same rate as a face-to-face visit. For subsequent inpatient visits (codes 99231 through 99233), only one visit every 3 days will be reimbursed. Of course, Medicare and some other insurers do not pay for consults (codes 99241 through 99245 and 99251 through 99255).

Synchronous telemedicine services rendered via a real-time interactive audio-video telecommunication system cannot be billed with a 95 or GT modifier on hospitalized new patients (codes 99221 through 99223) nor discharge day planning (codes 99238 and 99239). The requirements for care with synchronous telemedicine codes are the same as with standard face-to-face E/M codes, although verbal consent is considered standard at the beginning of the visit and it is suggested that both the patient's and provider's sites of service be documented. Because some parts of the neurologic examination, including, but not limited to, fundoscopic examination and visual fields, may be essential to being able to develop medical decision making, not all visits are appropriate for telehealth.

Case 4

A 25-year-old man with a history of repaired complex congenital heart disease had sustained a right middle cerebral artery stroke as a result of a septic embolus 2 weeks earlier and had been followed by a neurologist as an inpatient. His rehabilitation was proceeding well, with almost complete resolution of his left hemiparesis. Because he was doing well, the decision was made to discharge him to his parent's home while he completed his antibiotic therapy, with a follow-up visit to the neurologist scheduled in 1 month.

During the month, the COVID-19 public health emergency was declared, and the patient was offered a synchronous telemedicine visit with his neurologist as an alternative to the office visit. The patient was sent a link that allowed him to download software on his smartphone that created a secure connection to the electronic medical record software already installed on his phone. Fifteen minutes before the visit, the patient was sent a reminder to sign into his appointment and was greeted with a video and audio link to his neurologist, who was working from home that day, performing only telemedicine services. During the visit, the neurologist performed all the elements of a comprehensive history; several elements of the neurologic examination (mental status, examination of extraocular movements, testing of cranial nerves VII and XII); and a limited motor examination, as well as finger-to-nose testing, rapid alternating hand movements, foot tapping, gait, and balance. The examination showed continued improvement in the pronator drift, rapid alternating movements, and gait. No change in management occurred, and the decision was made to repeat a remote visit in 6 months.

Discussion. The total duration of the visit was 25 minutes, of which 15 minutes were spent discussing the risk of stroke recurrence and what lifestyle changes might lessen the future risk. The neurologist decided to bill for time because the time spent for counseling and coordination of care was greater than 50% of the 25-minute requirement for 99214, and, despite the high risk of the illness, a comprehensive examination could not be performed nor were the treatment options complex enough to warrant a 99215 code. The submitted *CPT* code was 99214 plus the 95 modifier.

Inpatient Synchronous Telemedicine Services

CMS has created separate G codes for inpatient telehealth using a synchronous audio-video connection in lieu of the *CPT* codes 99221 through 99223 and 99231 through 99233. These include three subsequent visit codes (G0406 [15 minutes], G0407 [25 minutes], and G0408 [>35 minutes]) and new inpatient codes (G0425 [30 minutes], G0426 [50 minutes], and G0427 [>70 minutes]).

CONCLUSION

American medicine has been slowly moving to develop care models that include remote E/M services. Although telemedicine for stroke neurology was quickly embraced by neurologists providing the services and the hospitals requesting the consultation, CMS and commercial payers initially only paid for services distant from metropolitan centers; however, the rule for nonrural sites changed in 2019. The expense of the remote consultation in medical facilities that did not meet payer reimbursement criteria was borne by the consulting hospital. For other neurology services, telemedicine was mainly a concierge service as carriers often restricted coverage for these services. Telephone encounters have never been reimbursed. Digital online management services are new, so their reimbursement history is not well established.

The COVID-19 public health emergency has created a situation in which it is not safe to congregate or travel and has forced all stakeholders of American medicine to consider novel ways to deliver health care. For the time being, HHS, CMS, state health departments, and commercial carriers have changed course and will reimburse for all these services. If this model is successful in the short term, it may be embraced by patients, providers, and the health care system as an alternative model to deliver E/M services to some patients in select situations.

USEFUL WEBSITES

AMERICAN ACADEMY OF NEUROLOGY COVID-19 NEUROLOGY RESOURCE CENTER

The American Academy of Neurology's COVID-19 Resource Center provides the latest information and resources for neurologists, including telemedicine resources, webinars and interviews, and articles.

aan.com/COVID19

AMERICAN ACADEMY OF NEUROLOGY TELEMEDICINE AND COVID-19 IMPLEMENTATION GUIDE

The AAN has developed guidance for clinicians and practices looking to implement telemedicine services amid the COVID-19 crisis. The guide contains information regarding technology best practices, regulations specific to the COVID-19 US public health emergency, tips on performing a remote neurologic examination, coding the visit, and more.

aan.com/siteassets/home-page/tools-and-resources/practicing-neurologist--administrators/telemedicine-and-remote-care/20-telemedicine-and-covid19-v103.pdf

AMERICAN ACADEMY OF NEUROLOGY TELEMEDICINE AND REMOTE CARE

Traditional medical practice is not always the most efficient or convenient way to provide care to our neurology patients. With an increasing demand for neurologic services in a growing population, technology can be one way to extend our reach to our patients. As technologies develop, it is paramount that practitioners maintain high-quality care, equivalent to traditional in-person visits. This web page is dedicated to providing resources to do so.

aan.com/telehealth

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