March 19, 2020: The Dept. of Healthcare and Family Services submitted an Illinois 1135 Waiver Request to CMS

**COVID-19 UPDATES**

**March 19, 2020:**
- HFS 1135 waiver application

**March 18, 2020:**
- Families First Coronavirus Response Act signed into law
- ICD-10 adopts WHO diagnosis code U07.1 (COVID-19)

**March 17, 2020:**
- Medicaid Telemedicine Fact Sheet and FAQs
- MAP and Part D Agencies

**March 16, 2020:**
- HFS Coronavirus and Expanded Care Options

**March 13, 2020:**
- CMS’ activation of blanket waivers

**March 10, 2020:**
- Fact Sheet and FAQs on coverage benefits

**March 12, 2020:**
- FAQ for State Medicare and CHIP

**March 10, 2020:**
- FAQ on State Survey Agencies

**March 10, 2020:**
- MAP and Part D guidance

**March 9, 2020:**
- EMTALA reminder

**March 9, 2020:**
- Telehealth benefits

**March 6, 2020:**
- Emergency funding bill

**March 6, 2020:**
- Covid-19 FAQs

**March 5, 2020:**
- 2nd HCPCS code for COVID-19 tests

**March 4, 2020:**
- call to action to providers

**February 28, 2020:**
- new HCPCS code for COVID-19 test

**February 20, 2020:**
- lab guidance

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On March 19, 2020, the Dept. of Healthcare and Family Services (HFS) submitted a request to the Centers for Medicare & Medicaid Services (CMS) to waive certain federal Medicaid, Children’s Health Insurance Program (CHIP), and Health Insurance Portability and Accountability Act (HIPAA) regulations during the COVID-19 public health emergency. If approved, this Section 1135 waiver would apply to services provided to Medicaid and CHIP beneficiaries under the fee-for-service and managed care programs. Highlights of the Section 1135 waiver request include:

- Waive the requirement that physicians and other healthcare professionals are licensed in the State of Illinois to serve Illinois Medicaid beneficiaries within Illinois or out-of-state, so long as they have an equivalent license in another state or Veterans Affairs or are enrolled in Medicare;
- Allow physicians to bill as the teaching physician when real-time audio video or access through a window is provided when hospitals are running low on supplies to limit the number of providers with direct patient contact;
- Permitting Medicaid payment for hospital outpatient observation services up to 48 hours, if not longer;
- Allowing prescribers not enrolled with Medicaid to write prescriptions for Medicaid patients; and
- Allowing non-HIPAA compliant telehealth modes for telehealth visits or check-ins at the location of the patient and certain waiving HIPAA sanctions and penalties for noncompliance.

Please see the HFS Section 1135 Waiver Letter and related fact sheet for a complete list of waiver requests. **These flexibilities are still subject to CMS approval.**

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The Families First Coronavirus Response Act (H.R. 6201) was signed into law on March 18, 2020. Healthcare coverage will be impacted as follows:

- Private health plans, Medicare Advantage plans, TRICARE, veterans plans, federal workers’ health plans and the Indian Health Service would be required to cover, at no cost to the patient, the COVID-19 diagnostic test. They would also be required to cover the patient’s visit to a provider, urgent care center or emergency room to receive the test.
- States would be permitted to extend Medicaid eligibility to their uninsured populations for COVID-19 diagnostic testing.
- The Secretary of HHS shall be providing a claims modifier to be used so that COVID-19 testing related services (such as below) will be identifiable on the Medicare claim for purposes of a specified outpatient payment methodology that will be applied.
  - Office and other outpatient services
  - Hospital observation services
  - Emergency department services
  - Nursing facility services
  - Domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services.

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**EMERGENCY TELEHEALTH WAIVER**

On March 17, 2020, CMS provided a fact sheet and FAQs which further clarifies the Medicare telehealth services that beneficiaries can receive under the President’s emergency declaration announced on March 13, 2020. Initial changes to Medicare Telehealth were triggered on March 6, 2020 when President Trump signed into law the emergency funding bill “Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020” which extended payment for telehealth services to all Medicare beneficiaries regardless of geographical location. Prior to this, the Social Security Act limited telehealth services to beneficiaries receiving care at authorized originating sites located mostly in rural areas. See CMS’ [Telehealth Services manual](http://compliance.bsd.uchicago.edu) for details on Original Telehealth.

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**Highlights from the CMS Fact Sheet and FAQs regarding Medicare Telehealth Services:**

- **No geographic or site restrictions:** Waiver of geographical restrictions for originating sites, allowing providers to provide telehealth services to patients from any location, including the patient’s home or any setting of care.
- **Smart Phones:** Telecommunication systems may include phones so long as they have audio and video capabilities (e.g., smart phone, face-time, Zoom) which allows for two-way, real-time interactive communication as long as it is not public facing (such as Facebook Live).
- **All Medicare Telehealth Services may be billed, not just services related to COVID-19:** Common telehealth services include 99201-99215 (Office or other outpatient visits), G0425-G0427 (Telehealth consultations, ED, or initial patient), G0406-G04048 (Follow-up inpatient telehealth consultations). For a complete list, go to CMS’ [List of Telehealth Services](http://compliance.bsd.uchicago.edu). (Follow-up inpatient telehealth consultations).
- **New or Established Patients:** Telehealth may be provided for “new or established patients (prior communication from CMS originally restricted Telehealth to established patients) *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.*
Providers are also reminded that in addition to Medicare telehealth services which are meant to take the place of a face-to-face office visit, they may also use Virtual Check-In codes (i.e., brief telephone call that mitigates the need for an in-person visit) and Electronic Visit codes (patient-provider evaluation provided via MyChart) as described at the end of this newsletter.

### Released March 17, 2020: HHS OIG Waives Telehealth Cost-Sharing During COVID-19

- The Department of Health and Human Services (HHS) Office of Inspector General (OIG) announced in its Policy Statement on March 17, 2020 that it would not impose administrative sanctions on physicians or other practitioners who reduce or waive cost-sharing for Federal health care program beneficiaries for telehealth services furnished during the COVID-19 public health emergency, which has existed since January 27, 2020. OIG’s guidance applies to all telehealth services furnished to Federal health care program beneficiaries during the COVID-19 public health emergency, and is not limited to telehealth services related to patients with COVID-19.
- OIG clarified that it will not bring an enforcement action under either the Federal anti-kickback statute or the beneficiary inducements civil monetary penalty statute for waiving or reducing such cost-sharing, provided all applicable CMS payment and coverage rules are met. Nothing in the Policy Statement requires a reduction or waiver of such cost-sharing amounts, nor does it otherwise affect a physician or practitioner’s responsibility to comply with other applicable laws and regulations.

### Released March 13, 2020: COVID-19 Emergency Declaration Health Care Providers Fact Sheet

President Trump’s declaration on March 13, 2020 of a national emergency due to COVID-19 gave CMS the authority to waive certain Medicare, Medicaid, and CHIP program requirements and conditions of participation under Section 1135 of the Social Security Act (“1135 waivers”). As a result, the following blanket waivers are available:

- **Provider Locations**: Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. This applies to Medicare and Medicaid.
- **Provider Enrollment**: Establish a toll-free hotline for non-certified Part B suppliers, physicians and non-physician practitioners to enroll and receive temporary Medicare billing privileges; waive the following screening requirements:
  - Application Fee – 42.CFR 424.514
  - Criminal background checks associated with FCBC – 42 CFR424.518
  - Site visits- 42 CFR424.517
- Postpone all revalidation actions and expedite any pending or new applications from providers
- *NOTE: This extends only to Medicare and Medicaid enrollment and reimbursement qualifications but it does not loosen restrictions on state licensure issues which require the provider to be licensed in the state in which the patient is located. States are continuing to waive licensure requirements as the situation evolves. We will keep you up to date if Illinois or surrounding states invoke this waiver.
- **Medicare appeals in Fee for Service, MA and Part D**: Extension to file an appeal and waiver of timelines for requests for additional information to adjudicate the appeal.
- **Skilled Nursing Facilities**: CMS is waiving the requirement for a 3-day prior hospitalization for coverage of a skilled nursing facility stay to provide temporary emergency coverage of SNF services without a qualifying hospital stay for those people who need to be transferred as a result of the effect of a disaster or emergency.

For details, see [COVID-19 Emergency Declaration Health Care Providers Fact Sheet](#)

### Coverage of COVID-19 Testing and Treatment by non-Medicare Payors

**MEDICAID**: As of March 16, 2020 Provider Notice, HFS will be putting out guidance and revising policies in the coming days and weeks to allow flexibility in provision of many important services. Per HFS, please immediately begin:

- Covering appropriate COVID-19 related testing and treatment for uninsured as well as Medicaid members;
- For providers who help patients in applying for coverage, submit completed medical applications without waiting for verification documents such as pay stubs;
- Providing needed services at alternate sites as you determine appropriate;
- Utilizing telehealth and telepsychiatry options in all available circumstances and sites (including non-traditional sites).
- Providing needed services without prior authorization for therapy services (physical, occupational and speech), supplies when requested amounts are over stated maximums, home health services and pharmacy items.

Effective immediately and through at least June 1, 2020, telehealth rules will be significantly broadened and will accommodate new places of service and means of engagement and communication. We recommend all providers utilizing telehealth of any kind to continue practicing the same level of documentation as for in person visits.

**BlueCross BlueShield of Illinois**:

**Waiver of prior authorization and member co-pays or deductibles**: Effective March 10, 2020, BCBSIL began covering telehealth “virtual” visits with in-network Illinois providers for the PPO and Blue Choice Members. This means that members will now have that service covered as a regular office visit. BCBSIL will waive requirement for prior authorization and member co-pays or deductibles for testing to diagnose COVID-19 when medically necessary and consistent with CDC guidance. This applies to all members they insure. With regard to treatment for COVID-19, plans cover medically necessary health benefits, including physician services, hospitalization and emergency services consistent with terms of the member’s plan.
**AETNA:**  
**Waiver of co-pays for testing:** Aetna will waive co-pays for all diagnostic testing related to COVID-19. This policy will cover the cost of physician-ordered testing for patients who meet CDC guidelines, which can be done in any approved laboratory location. Aetna will waive the member costs associated with diagnostic testing at any authorized location for all Commercial, Medicare and Medicaid lines of business. Self-insured plan sponsors will be able to opt-out of this program at their discretion.  
**For the next 90 days, until June 4, 2020, Aetna will offer zero co-pay telemedicine visits – for any reason.** Aetna members should use telemedicine as their first line of defense in order to limit potential exposure in physician offices. Cost sharing will be waived for all virtual visits through the Aetna-covered Teladoc® offerings and in-network providers delivering synchronous virtual care (live video-conferencing) for all Commercial plan designs. Self-insured plan sponsors will be able to opt-out of this program at their discretion.  
**Aetna is also offering its Medicare Advantage brief virtual check-in and remote evaluation benefits to all Aetna Commercial members and waiving the co-pay.** These offerings will empower members with questions or concerns that are unrelated to a recent office visit and do not need immediate in-person follow-up care to engage with providers without the concern of sitting in a physician’s office and risking potential exposure to COVID-19.

**HUMANA:**  
**Testing is fully covered.** Testing for COVID-19 will be fully covered with no out-of-pocket costs for patients who meet CDC guidelines at approved laboratory locations. This applies to members of Humana’s Medicare Advantage, Medicaid and commercial employer-sponsored plans. The CDC continues to offer free testing for coronavirus.  
**Telemedicine visits for all urgent care needs are fully covered.** To help reduce the risk of infection and spread of disease, Humana is encouraging members to use telemedicine (e.g., video chat) as a first line of defense for all urgent care needs. Humana will waive out-of-pocket costs for telemedicine visits for urgent care needs for the next 90 days. This will apply to Humana’s Medicare Advantage, Medicaid and commercial employer-sponsored plans, and is limited to in-network providers delivering live video-conferencing. Humana is working closely with federal agencies to understand the impacts of both telemedicine and the coronavirus test on High Deductible Health Plans and Health Savings Accounts.

**United Healthcare**  
**Tests fully covered:** United Healthcare is waiving costs for COVID-19 testing provided at approved locations in accordance with CDC guidelines. Applies to Medicare and Medicaid members as well as their commercial insured members. Also supporting self-insured employer customers who chose to implement similar actions.  
**Telehealth resources:** Encourages members to use virtual visits as provided by Medicare, Medicaid and employer health plans.

**Cigna**  
**Waiver of co-pays for testing:** Through May 31, 2020, Cigna will waive customer’s out-of-pocket costs for COVID-19 testing-related visits with in-network providers, whether at a doctor’s office, urgent care clinic, emergency room, or by virtual care options such as talking with a doctor or clinician 24/7 by phone, tablet, or computer.

**Illinicare** - Illinicare directs members to this link about COVID-19 and Aetna Providers. See Aetna section above for details.

**Countycare** – Countycare’s site currently does not speak to any changes in coverage with respect to COVID-19.

## COVID-19 Diagnosis Coding

<table>
<thead>
<tr>
<th>Confirmed Cases of COVID-19</th>
<th>COVID-19 Test Codes</th>
</tr>
</thead>
</table>
| Code U07.1 (COVID-19) | **MEDICARE HCPCS CODES:** Medicare claims processing systems can accept these new codes starting 4-1-20 for dates of service on or after 2-4-20.  
- **U0001** Released 2-6-20; applies to CDC’s 2019 Novel Coronavirus Real Time RT-PCR Diagnostic Test Panel Assay. For authorized CDC testing laboratories to test patients for SARS-CoV-2. NGS Payment Rate is $35.91.  
- **U0002:** Released 3-5-20; allows labs to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). NGS Payment Rate is $51.31  
**AMA CPT CODE:** Effective 3-13-20, a new CPT code is available for novel coronavirus testing by hospitals, health systems and labs in the U.S. The CPT Editorial Panel approved the code at a special, expedited meeting held Friday, March 13, 2020.  
- **87635:** Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), amplified probe technique  
**Resources:**  
- [AMA CPT Announcement](#) |

**Signs/symptoms**

When the patient is exhibiting signs and symptoms but a definitive diagnosis has not been established, the CDC instructs that you code only the presenting signs and symptoms, such as:

- **R05 (Cough),**
- **R06.02 (Shortness of breath) or**
- **R50.9 (Fever, unspecified).**

### COVID-19 Diagnosis Coding

On March 18, 2020, ICD-10-CM announced that it would adopt the World Health Organization (WHO) code U07.1 (COVID-19), effective April 1.  

- **Conformed Cases of COVID-19**  
  - Code U07.1 as the primary code  
  - Pneumonia and all other manifestations should also be coded.  

**Concern about exposure to COVID-19**  

For cases where there is concern about a possible exposure to COVID-19, but this is ruled out after evaluation,” report code Z03.818 (Encounter for observation for confirmed exposure to a confirmed case of COVID-19) or Z20.828 (Contact with and [suspected] exposure to other viral respiratory disease, e.g., SARS-CoV-2).  

**Actual exposure to a confirmed case of COVID-19**  

Report code Z20.828 (Contact with and [suspected] exposure to other viral communicable diseases).  

**Resources:**  
- [AMA CPT Announcement](#) of new code
Prior to April 1: Providers can continue to report based on previously published interim guidelines, which outlines, among other things, how to report illnesses caused by COVID-19 with two codes. For example:

**Bronchitis**
- Acute bronchitis due to COVID-19: Assign code J20.8 (Acute bronchitis due to other specified organisms and B97.29).
- Bronchitis not otherwise specified (NOS) caused by COVID-19: J40 (Bronchitis not specified as acute or chronic) and code B97.29.

**Lower respiratory infection**
- Lower respiratory infection, not otherwise specified (NOS) or acute respiratory infection caused by COVID-19: Report code J22 (Unspecified acute lower respiratory infection) and code B97.29.
- Respiratory infection NOS caused by COVID-19: Code J98.8 (Other specified respiratory disorders) and code B97.29.

**Acute respiratory distress syndrome (ARDS)**
- ARDS due to COVID-19: Report codes J80 (Acute respiratory distress syndrome) and code B97.29.

### AVAILABLE CODES THAT PROVIDERS CAN USE DURING COVID-19 PUBLIC HEALTH EMERGENCY

<table>
<thead>
<tr>
<th>NAME OF CODE</th>
<th>REQUIREMENTS</th>
<th>EXAMPLES</th>
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<tbody>
<tr>
<td><strong>Medicare Emergency Telehealth Services</strong></td>
<td>Billing Providers: Physicians, Nurse practitioners, Physician Assistants, Certified nurse midwives, as well as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, an registered dieticians or nutrition professionals within their scope of practice and consistent with Medicare benefit rules that apply to all services.</td>
<td>CPT 99212: Patient requests appointment with physician to discuss pain he has been having in right arm. Visit is conducted between Physician and patient via Skype. Physician collects HPI, ROS, PMFH and documents the visit as he would have for an in-person visit. He includes a statement that more than 50% of time was spent in counseling. Provider bills 99213 based on total time spent during visit.</td>
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<td></td>
<td>Patient Type: new and established patients; services do not have to be related to COVID-19 under the waiver</td>
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<td>Telecommunication Technology: Technology that has audio and video capabilities that are used for two-way, real-time interactive communication as long as it is not public facing (such as Facebook Live). This includes Zoom, FaceTime, Smart phones, and mobile computing devices. Audio/video capabilities must be available but providers do not have to use them. The Office for Civil Rights will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patient in good faith through such everyday communications technologies like Skype and FaceTime.</td>
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<td>Billing for Service: Medicare telehealth services are generally billed as if the service had been furnished in-person. The claim should reflect the designated Place of Service (POS) code 02-Telehalth to indicate the billed service was furnished as a professional telehealth service from a distant site.</td>
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<td>Medicare payment for telehealth services: Starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare Telehealth Services furnished to patients in broader circumstances. These are paid at the same amount as it would if the service were furnished in person.</td>
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<td>Beneficiary out of pocket costs: While telehealth does not change out of pocket costs for beneficiaries with Original Medicare (e.g., deductable and coinsurances), the OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.</td>
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<td>On-site visits conducted via video or through a window in the clinic suite: Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.</td>
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### Coverage and Payment Guidance Related to COVID-19

**Updated March 20, 2020**

<table>
<thead>
<tr>
<th>HCPCS G2012- Virtual Check-In</th>
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<tr>
<td>Brief (5-10 minutes) medical discussion via communication technology-based service between a patient and qualified health care professional. The purpose of these calls is to determine if a follow-up visit is required.</td>
</tr>
<tr>
<td><strong>Billing Providers:</strong> those who can bill E/M (physicians/ NPs/PAs). Telephone calls completed by clinical office staff do not qualify for use of this code.</td>
</tr>
<tr>
<td><strong>Patient Type:</strong> Established patients only</td>
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<tr>
<td><strong>Locations:</strong> All locations, including patient’s home</td>
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<tr>
<td><strong>Related E/M Services:</strong> Service can bear no relation to an E/M service within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).</td>
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<tr>
<td><strong>Technology:</strong> Real-time, two-way audio only (i.e., telephone); may be enhanced with video or other data transmission (excludes voice messages- must be a live conversation).</td>
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<tr>
<td><strong>Initiation:</strong> Patient initiates service</td>
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<tr>
<td><strong>Time Requirements:</strong> 5–10 minutes of medical discussion required.</td>
</tr>
<tr>
<td><strong>Frequency:</strong> No frequency limitation; CMS will monitor frequency to determine whether a limit is necessary</td>
</tr>
<tr>
<td><strong>Documentation:</strong> Provider documents date, time, duration of service along with brief summary of topic(s) discussed.</td>
</tr>
<tr>
<td><strong>Consent:</strong> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</td>
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<tr>
<th>HCPCS G2010-Remote Evaluation of Prerecorded Patient Information</th>
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<tr>
<td>Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours</td>
</tr>
<tr>
<td><strong>Billing Providers:</strong> those who can bill E/M (physicians/ NPs/PAs).</td>
</tr>
<tr>
<td><strong>Patient Type:</strong> Established patients only</td>
</tr>
<tr>
<td><strong>Locations:</strong> All locations, including patient’s home</td>
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<tr>
<td><strong>Technology:</strong> Follow-up may take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication. Such communication must be compliant with HIPAA and other relevant laws.</td>
</tr>
<tr>
<td><strong>Initiation:</strong> Patient initiates service</td>
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<tr>
<td><strong>Related E/M Service:</strong> Service can bear no relation to an E/M service within the prior seven days, or result in an E/M service within the ensuing 24 hours (or soonest appointment).</td>
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<tr>
<td><strong>Frequency:</strong> No frequency limitations; CMS will monitor utilization.</td>
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<tr>
<td><strong>Documentation:</strong> Provider documents review and interpretation of images and also date and time of beneficiary contact and content discussion. When the quality of the prerecorded information is insufficient to allow the clinician to assess the need for medical treatment, the service may not be billed.</td>
</tr>
<tr>
<td><strong>Consent:</strong> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</td>
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<tr>
<th>Online Digital Evaluation and Management Services (e-Visit)</th>
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<tbody>
<tr>
<td>For Physicians and qualified healthcare practitioners that can bill E/M codes, online digital E/M service, cumulative time 99421: 5-10 min up to 7 days 99422: 11-20 min up to 7 days 99423: 21 or more min up to 7 days</td>
</tr>
<tr>
<td><strong>Non-physician practitioners who are unable to bill E/M services.</strong> G2061: 5-10 min up to 7 days G2062: 11-20 min up to 7 days G2063: 21 or more minutes up to 7 days</td>
</tr>
<tr>
<td><strong>New codes as of CY20 Physician Fee Schedule Final Rule</strong></td>
</tr>
<tr>
<td><strong>E-Visit Definition:</strong> non-face-to-face “patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.”</td>
</tr>
<tr>
<td><strong>Billing Providers:</strong> CPT codes 99421-99423 are reserved for physicians and other healthcare practitioners that can directly bill Medicare E/M codes. CMS created HCPCS codes G2061, G2062, and G2063 for non-physician practitioners who are unable to bill E/M services.</td>
</tr>
<tr>
<td><strong>Patient Type:</strong> Established patients only</td>
</tr>
<tr>
<td><strong>Locations:</strong> All locations, including patient’s home</td>
</tr>
<tr>
<td><strong>Digital Service:</strong> electronic health record portal, secure email or other digital applications</td>
</tr>
<tr>
<td><strong>Initiation:</strong> Patient initiates service via digital platform, but follow-up by the provider may include telephone.</td>
</tr>
<tr>
<td><strong>Related E/M Services:</strong> If the patient had an E/M service within the last seven days, or has a face 2 face E/M visit related to the problem in the next 7 days, these codes may not be used.</td>
</tr>
<tr>
<td><strong>Frequency:</strong> Services may only be reported once in a 7-day period. Clinical staff time may not be counted.</td>
</tr>
<tr>
<td><strong>Consent:</strong> patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)</td>
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</table>

| Established patient contacts primary care provider via MyChart with complaints about fatigue and flu-like symptoms. Provider reviews medical history, formulates diagnosis, treatment plan, and sends in prescription. Provider calls patient to discuss plan. This totals 15 minutes over 7 days. Provider documents service in the record, and bills CPT code 99422. |
Telephone evaluation and management visits by a physician or QHCP who may report E/M services

99441 5-10 min
99442 11-20 min
99443 21-30 min

Telephone assessment and management services by a qualified non-physician health care professional who may not report E/M services

98966 5-10 min
98967 11-20 min
98968 21-30 min

• NOTE: these codes are not paid by Medicare currently
• Billing Provider 99441-99443: Physicians and QHCP who may report E/M services
• Billing Provider 98966-98968: Non-physician who may not report E/M services (e.g. speech-language pathologists, physical therapists, occupational therapists, social workers, dieticians)
• Patient Type: Established patient only
• Locations: All locations, including patient’s home
• Initiation: Patient must initiate service
• Related E/M Services: May not originate from a related E/M service provided in the previous 7 days or leading to an E/M service or procedure within the next 24 hours or soonest available appointment
• Consent: Patient must verbally consent to receive check-in services (Medicare co-insurance and deductibles would apply)

Established patient to the provider/specialty calls and speaks to physician regarding flu-like symptoms. Provider spends 10 minutes in medical discussion and ultimately tells the patient to stay home and rest, drink fluids. No follow-up face to face E/M visit needed. Provider documents service in the record and bills 99441.