Health Information Compliance Alert

Revenue Booster: Master Virtual Check-In Coding With This Primer

Tip: Stick to one set of codes for reporting until the PHE ends.

No matter the specialty, telehealth visits have increased exponentially during the COVID-19 public health emergency (PHE). However, even though many have bolstered their command of coding these services over the past year, the same can't be said for audio-only virtual check-in visits.

Why? The Centers for Medicare & Medicaid Services (CMS) introduced a new virtual check-in code in the Medicare Physician Fee Schedule (MPFS) 2021 final rule that understandably got lost in the shuffle among juicier headlines. While this code may seem to be an eligible contender for Medicare Part B reporting, there are a few good reasons why you should avoid it.

Read on for a deep dive on synchronous audio exchanges, typically via telephone, that qualify as virtual check-in services to ensure you're coding compliantly and maximizing your bottom line.

See What's New With 2021 Virtual Check-in Coding

At the beginning of the public health emergency (PHE), the feds introduced a plethora of coding guidance on how to report telehealth services, virtual check-ins, and e-visits. Despite the attention paid to telehealth coding over the course of the pandemic, virtual check-ins remain an integral part of evaluation and management (E/M) services and will continue to be critical as the PHE extends through 2021.

Refresher: Technically, a virtual check-in includes any brief patient communication with a provider via a number of communication technology modalities. These may include telephone or asynchronous (staggered response) exchanges through video or image. While the concept is generally straightforward, the coding dynamics require some extra attention to detail in order to ensure a provider is not only billing for the correct services, but is also compensated appropriately.

The release of the MPFS 2021 final rule added to the confusion concerning the correct codes to report for Medicare Part B and other commercial payer virtual check-in services. Plus, there were more questions than answers after the recent introduction of the following HCPCS Level II code:

- G2252 (Brief communication technology-based service, e.g. 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; 11-20 minutes of medical discussion)
- As CMS puts it, this is essentially an indented code to G2012 (... 5-10 minutes of medical discussion) and is eligible for Medicare Part B (and other eligible commercial payer) reporting.

Consider Provider Eligibility for Some Virtual Check-in Codes

Practices' first point of order is to distinguish G2252 from the following two new virtual check-in codes, also released in 2021:

- G2250 (Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and

forward...))
- G2251 (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services... 5-10 minutes of clinical discussion)

These codes are designated to be reported by practitioners who cannot independently bill for E/M services. CMS refers to G2250 and G2251 as "sometimes therapy," which may be billed by a private practice physical therapist (PT), occupational therapist (OT), or speech language pathologist (SLP), among other nonphysician providers (NPPs). Alternately, G2010 (Remote evaluation of recorded video and/ or images submitted by an established patient (e.g., store and forward) ...) should be reported for store and forward services by advanced practice providers (APPs) treating patients with Medicare Part B and other eligible payers.

Maximize Reimbursement With These Coding Adjustments

With the release of G2252, the underlying question E/M coders are now scrambling to answer is whether to report G2012 and G2252 in place of the following CPT® codes for telephone-based E/M services:

- 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)

Reminder: In March of 2020, CMS announced that it would temporarily extend coverage for 99441-99443 as virtual check-in service codes for the duration of the PHE. CMS explains in the 2021 MPFS final rule that G2012 and G2252 are direct crosswalks to 99441 and 99442, respectively. Furthermore, considering that CMS extended coverage to 99441-99443, and the 99441-99443 respective fee schedules offer substantially more compensation than G2012 and G2252, the question begs: What circumstances, if any, should G2012 and G2252 be reported for eligible clinical virtual check-in services?

Fortunately, the answer is as straightforward as it seems while the PHE is ongoing. Until CMS announces coverage of 99441-99443 has ceased, practices should be reporting it for all eligible (Medicare Part B and otherwise) telephone-based virtual check-in services. That's in part because the fee schedule for 99441-99443 yields substantially more reimbursement than G2012 and G2252. Furthermore, CMS' creation of a crosswalk between code sets does not mean that both codes sets will be reimbursed the same. The respective fee schedules for both code ranges still apply. Keep in mind that on a longer timeline, the answer isn't as straightforward until Congress makes a legislative decision on the future of telehealth.

Coder's note: The 99441-99443 code description clearly indicates the known eight-day exclusion rule, in which the virtual check-in may not originate from a related E/M service within the prior seven days, nor may you report it when the check-in leads to an E/M service within the next 24 hours (or soonest available appointment thereafter). "However, keep in mind that there's at least one Medicare Administrative Contractor, NGSMedicare, that has eliminated those exclusion dates," says **Barbara J. Cobuzzi, MBA, CPC, COC, CPC-P, CPC-I, CENTC, CPCO,** of CRN Healthcare in Tinton Falls, New Jersey. "Check with your local MAC to confirm that the eight-day exclusion period still applies," Cobuzzi advises.

Final tip: "CMS notes that there are several modifiers you should consider for your telehealth claims," advises **Carol Pohlig, BSN, RN, CPC, ACS,** senior coding and education specialist at the Hospital of the University of Pennsylvania. However, the rules for telehealth modifier application do not apply to virtual check-in services.