AUGS
Advancing Female Pelvic Medicine and Reconstructive Surgery

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Telehealth Services

Medicare has typically placed many restrictions on telehealth services such as geographical and specialty specific limitations. However, in 2019 Medicare expanded its use of telehealth services and provides reimbursement for those encounters traditionally rendered in a face-to-face setting, such as consultations, office visits and psychiatric services. Centers for Medicare and Medicaid Services (CMS) defines these services as "assessment and management services conducted through telephone, internet, or electronic health record consultations," without the patient being physically present.

The Virtual Check-in

G2012, the virtual check-in, is an example of the new telehealth code set expansion. The descriptor for this code describes the code and qualifies its use. The virtual check-in is a brief (5-10 min), patient-initiated communication by telephone, email or virtual private messaging system to an eligible provider with whom the patient is established, to discuss a problem in order to see if a face-to-face encounter is necessary. The definition of "established patient" has not changed.

The virtual check-in cannot be the result of an evaluation and management (E/M) service within the previous 7 days, nor can it lead to a face-to-face encounter within the next 24 hours. If it overlaps those qualifications, it will be bundled into the face-to-face encounter and not paid separately.

G2012 takes the place of 99441, which was similar in description, but included only telephonic technology.

G2012 requires the patient be informed of the chargeable encounter and provide verbal permission to proceed with the encounter during each instance because a patient co-payment may apply, dependent on the patient's insurance contract. No frequency limit or documentation requisites have been defined except medical necessity and confirmation of verbal consent. This encounter may only be used by the billing practitioner and excludes ancillary staff. Please note: **The medical record must reflect the patient's verbal consent for each instance of communication in order to bill for the service.** Keep in mind as stated above, **only established patients** are eligible for this service.

Pre-Recorded Patient Information

CMS is also authorizing payment for review and evaluation of pre-recorded patient information, so called "store and forward" video or imaging technology, under the code **G2010**. Limitations are similar to the virtual check-in code, i.e. it must be patient-generated, cannot be within 7 days after or 24 hours before a face-to-face meeting, and verbal or written consent must be documented with each episode. Additionally, follow up to the patient by telephone, audio/visual technology, or secure text messaging or email within 24 hours must be performed by the provider. Again, this service is billable only for established patients.

Developed by the AUGS Coding and Reimbursement Committee in February 2019.

Interprofessional Internet Consultation

Six additional telehealth service codes reimbursable by CMS include interprofessional telephone/internet/electronic consultations without the patient being present. These codes are meant to supplant the need for face-to-face interaction by the patient with the consulting physician. **99451 and 99452**, Interprofessional telephone/internet/electronic health record assessment and management services may be submitted by the consulting and consultative physician for consultation performed via electronic health record. 99451 does not require written report to the patient's requesting provider, while 99452 does require this. These codes are time-based and should document patient consent for each consultation due to patient cost-sharing requirements.

Four similar codes: **99446, 99447, 99448, 99449,** are utilized when a consulting physician performs an interprofessional consultation for an established patient from a treating physician via telephone/internet/electronic health record assessment. Again, these codes are time-based, and the consulting physician is required to supply a consultation document to the treating physician for each code.

Code Differences

99446-99449 require verbal and written feedback and over half of the time must be spent in the verbal/electronic feedback format. *"The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion."* 99451-99452 doesn't necessitate the interprofessional verbal/electronic communication component as consultation may involve EHR interaction only and may be billed if more than 50% of the time involves data analysis with only 99452 requiring a written report to the requesting provider.

Telehealth Service Code Comparison:

Code	Provider	Timing
99446	Consulting	5-10 minutes
99447	Consulting	11-20 minutes
99448	Consulting	21-30 minutes
99449	Consulting	>30 minutes
99451	Treating/requesting	5-29 minutes
99452	Treating/requesting	30 minutes

Codes **99441, 99442,** and **99443**, evaluation and management codes by telephone only, are currently CMS non-covered services. Other telehealth codes involving remote physiologic monitoring of chronically ill patients, opioid substance abuse counseling, and other indications extend beyond the normal scope of urogynecology and are not covered in this fact sheet.

Clinical Case Scenario

A 69-year-old female goes to her gynecologist complaining of pelvic pain with urinary frequency and urgency, and nocturia 6 times nightly. A urine culture showed no growth, but a urinalysis showed numerous white cells and red blood cells. Further workup included a CT scan, cystoscopy and

urodynamic exam. The gynecologist suspects interstitial cystitis/bladder pain syndrome (IC/BPS) but needs help with the diagnosis and treatment protocols. The patient does not want to travel the 100 miles to the nearest urogynecologist. The treating gynecologist has a relationship with the urogynecologist and contacts him with the patient's permission via secure, real-time internet audio visual technology, and goes over the history, physical findings and transmits the pictures of the CT, cystoscopy and urodynamics. The consulting physician confirms the likely diagnosis and provides the step-wise treatment protocols for IC/BPS with the gynecologist. The entire transmission takes 21 minutes.

In this scenario the treating gynecologist will be able to submit code **99451.** The consulting urogynecologist will submit **99448** and send a formal document to the gynecologist regarding the consultation findings and advice rendered. One might think that the urogynecologist may also submit **G2010** in this case as well; however, this code would not apply because the service was not patient initiated but initiated by the treating provider.

RVU's

Code	RVUs	Reimbursement
G2010	0.18	6.49
G2012	0.25	9.01
99446	0.35	12.62
99447	0.70	25.24
99448	1.05	37.85
99449	1.40	50.47
99451	0.70	25.24
99452	0.70	25.24

References

The Federal Register. Vol 63. No. 226. November 23, 2018. Found at https://www.govinfo.gov/content/pkg/FR-2018-11-23/pdf/2018-24170.pdf