The COVID-19 public health emergency (PHE) has created an opportunity for a significant expansion of telehealth services across the spectrum of healthcare services and payers. The Centers for Medicare and Medicaid Services (CMS) has promulgated substantial new regulatory guidance to expand the availability of telehealth.

Providers bill for all types of visits using the Common Procedural Technology (CPT) Evaluation and Management (E&M) codes published and maintained by the American Medical Association, with additional regulatory guidance from CMS for governmental payers. Because there are challenging aspects to documenting a telehealth visit, CMS is allowing physicians who perform telehealth services to prematurely adopt a modified version of the CPT coding changes previously scheduled to go into effect January 1, 2021 for office and outpatient hospital services (CPT codes 99201-99215). These “new” documentation standards are only for telehealth visits that will be billed using the 99201-99215 series of codes and do not apply to in-person visits or other types of E&M services (such as inpatient visits) even if performed via telehealth.

Historically, E&M service codes require the documentation of various levels of history, physical examination, and medical decision-making that are defined in the CMS 1995 and

Some of the changes to the Medicare program include:

- Use of non-HIPAA-compliant technologies such as Facetime and Skype;
- Telehealth visits with a patient who remains at home;
- Increased coverage for telephone and digital (computer) based services;
- Addition of services not previously covered via telehealth;
- Additional flexibilities for Rural Health Clinics; and
- Payment at the non-facility rate for services that normally would have been performed in an office setting.
Relaxation of the telehealth rules extends only for the life of the PHE. Congress must act for the changes to become permanent.

The ability to provide telehealth services via non-HIPAA-compliant software such as Facetime or Skype will most likely be withdrawn later because of privacy concerns.

The range of telehealth services allowed during the PHE may be temporary.

Payment for telehealth service provided in the office may be adjusted to the facility rate after providers have had the opportunity to adjust overhead.

Coding requirements for office/outpatient telehealth services are based on medical decision making or time. Although there is no documentation requirement for history or physical examination, CMS expects a medically appropriate history or physical examination to be present in the medical record.

Office/outpatient hospital services performed face-to-face still require history, physical examination and medical decision-making.

The time increments associated with billing by time are not the typical times listed in the CPT book. The correct time increments are noted in the 2020 Physician Fee Schedule Final Rule public-use files and are longer than the CPT time increments.

Any time-based service requires that the provider document the time.

Non-governmental payers may have different rules, so providers should work with their commercial payers to determine what services they will cover and the appropriate codes and modifiers.
The strain placed on the provider world by the PHE has resulted in changes to the telehealth world that normally would have taken years to put into action. Although some changes will be done away with after the current emergency ends, both patients and providers will most likely push for other regulatory changes to remain, as they have come to appreciate the efficiencies that telehealth offers.