Society of Gynecologic Oncology

Telemedicine Coding Examples

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In follow up to the SGO April 10, 2020, webinar entitled "**Telemedicine for Gynecologic Oncology Care During the COVID-19 Pandemic**," below are a series of eight clinical scenarios for telemedicine coding. On March 17, 2020, the Centers for Medicare and Medicaid Services (CMS) agreed to pay providers to care for Medicare beneficiaries for office and hospital visits via telehealth anywhere in the United States. This went to effect retroactively on March 6, 2020, and will continue through the COVID-19 pandemic. Each clinical case has an example of how to code the encounter. This will vary on geographic location, practice setup, and changing regulations with COVID-19. After the clinical case scenarios there is a list of resources to assist with coding.

Clinical Scenario 1

A 54-year-old woman with prior history of stage IVB endometrial cancer. She was diagnosed in 2018. Most recently she has been on a combination of letrozole and everolimus for 6 months. She had a CT recently and has an upcoming visit. She was encouraged to have a telehealth visit as she was not enthusiastic about leaving her house and traveling to our office during the pandemic.

The office staff contacted her and instructed her on how to set up a telehealth visit on the platform for our enterprise. Ten minutes before the visit she contacted the office to say that she was having difficulty signing on. Despite multiple attempts, she could not establish a video connection, and the visit was conducted by audio on phone only. Typically, our audiovisual platform allows for consent of the patient when signing on, but this could not happen. Upon establishing audio connection, the provider reviewed with the patient the exact same consent process, identified her and the patient understood that she will receive a charge for services performed. She agreed to this.

Her current symptoms were reviewed, and an interim history was obtained from the past 4 weeks, as she had been seen by the office NP at that time. Since her last visit she is having a great deal of joint pain—some related to letrozole, but also due to recurrence in the pelvis resulting in a fracture of left pubic bone and enlargement of the tumor in adductor muscles. She is experiencing anemia from everolimus. She has proteinuria and is managed by nephrology, and her Cr level remains stable. Her most recent CT shows progression of disease with development of malignant ascites and pleural effusion.

During this visit the provider and patient did the following:

1. Reviewed a new treatment plan with pembrolizumab and lenvatinib, including all side effects and expected response rates, frequency of treatments, and imaging for assessment of response was determined.
2. Discussed several modalities of pain management, including availability of medical marijuana and risks, benefits.
3. Discussed her ongoing but relatively stable medical issues including diabetes, nephropathy and hypertension and the effects of this treatment on them. Dosing of lenvatinib was reduced for reasons related to her hypertension.

4. Discussed issues related to her goals of treatment, availability of social support at home, ability to accomplish her goals and finally reconsidered her living will and durable Power of Attorney (POA).

Diagnoses: C54.1 Endometrial cancer, C79.51 Metastasis to bone, R18.0 Ascites, J90.0 Pleural effusion, M25.351 Pain, right hip, M54.9 Back Pain, E11.9 Diabetes, R80.9 Albuminuria

Time spent face-to-face today was 25 minutes with an additional 10 minutes used to document. Medical decision making was high and complex. In the documentation of the encounter, the failed attempt at telehealth was noted as was the patient's verbal consent for the encounter. Total minutes for the encounter was documented in the note.

99214-GT (2.22 RVU) Level 4 was selected based on complexity of medical decision making even though an exam was not performed. Some would argue a Level 5 (99215-GT, 3.14 RVU) charge may even be appropriate here given the complexity, but it really depends upon the time you have documented in the chart and complexity you have portrayed. Time of the visit was considered. GT modifier was added for telehealth platform. Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. The -95 modifier is appropriate for Medicare patients who have telehealth visits. And –GT is also a modifier for non-Medicare patients indicative of a Telehealth visit.

Clinical Scenario 2

A 71-year-old woman with a history of Stage IB, grade 3 endometrial cancer 4 years ago due for her routine surveillance visit during the COVID-19 pandemic crisis. She lives in New Jersey, and the physician practices in Pennsylvania.

The office staff has called the patient to change her office visit to a telemedicine visit after confirming her access to a computer and that she has no specific concerns.

After establishing a video conference line with her and exchanging pleasantries, the physician obtained consent with the following script that is in the note:

> "Hello, my name is Dr. (Insert Name). Before we proceed, can you please verify your identification by telling me your full name and date of birth? Can you tell me who is in the room with you?
>
> "You and I are about to have a telemedicine check-in or visit because you have requested it. This is a live video-conference. I am a real person, speaking to you in real time. There is no one else with me on the video-conference. However, when we use (FaceTime, Skype, etc.) it is important for you to know that the video-conference may not be secure or private. I am not recording this conversation and I am asking you not to record it. This telemedicine visit will be billed to your health insurance or you, if you are self-insured. You understand you will be responsible for any copayments or coinsurances that apply to your telemedicine visit. Before starting our telemedicine visit, I am required to get your consent for this virtual check-in or visit by telemedicine. Do you consent?"
>
> Patient Response to Request for Consent: "Yes"

The provider reviewed and documents that there are no changes to her medical, surgical, social or family histories, her medications and allergies. The provider documents a review of systems, and goes over her blood pressures from the patient's home BP cuff, which are sometimes 140/80. The provider assures the patient she has no symptoms consistent with recurrent endometrial cancer.

They review symptoms of endometrial cancer, discuss the importance of taking her BP meds daily but to call her medical doctor or gynecologic oncologist if the BPs continue to stay elevated. The provider sends a screening mammogram script to her, and they plan for a full examination in 6 months. The physician documents that 26 minutes were spent on the call.

Diagnosis: C54.1 Endometrial cancer, I10 Hypertension

Final Code: 99214-95 (2.22 RVU)

Office encounters like this are a daily fact of life during the current pandemic, and may continue to be performed in the foreseeable future. This case demonstrates two things: E&M coding can be done with video telemedicine visits and interstate telemedicine is allowable under certain circumstances.

CMS has recently published a good summary statement about telemedicine during the pandemic crisis: **cms.gov/files/document/covid-19-physicians-and-practitioners.pdf**. For this case, the key points are a documented complete update to the history and the level of Medical Decision Making. A provider can bill for a Level 4 visit since because one chronic stable problem (endometrial cancer) and a chronic worsening issue (hypertension) are being addressed. Documenting the time taken to perform the video chat, as well as any preparation or documentation, can also establish a level of service.

Second, CMS is allowing interstate telemedicine care if it is allowed by the state medical licensing rules. In this case, New Jersey is temporarily letting out-of-state physicians practice with only an online application. Pennsylvania requires a written request. You should check with the state authorities in your state as well as your patient's state to see your local requirements. For the duration of the COVID-19 emergency, CMS is permitting interstate telemedicine.

Last, for any E&M coding for telemedicine, the -95 modifier is added to indicate a video telemedicine encounter.

Clinical Scenario 3

A 78-year-old with new diagnosis of grade 2 endometrial cancer on EMB presents for telemedicine encounter. She is called by the office medical assistant 10 minutes before her visit and instructed on how to sign into the patient portal application through her smartphone. Upon logging in for the visit she reads the following statement and agrees in order for the telemedicine encounter to begin.

Name of patient - I agree to be treated via a video visit and acknowledge that I may be liable for any relevant copays or coinsurance depending on my insurance plan. I understand that this video visit is offered for my convenience and I am able to cancel and reschedule for an in-person appointment if I desire. I also acknowledge that sensitive medical information may be discussed during this video visit appointment and that it is my responsibility to locate myself in a location that ensures privacy to my own level of comfort. I also acknowledge that I should not be participating in a video visit in a way that could cause danger to myself or to those around me (such as driving or walking). If my provider is concerned about my safety, I understand that they have the right to terminate the visit.

During this visit the provider and patient did the following:

1. Reviewed endometrial cancer treatment options including surgery, empiric radiation, and hormonal management.
2. Discussed risks, benefits, alternatives to surgery.
3. Planned for preoperative medical clearance with referrals, orders for imaging and laboratory tests were placed.
4. Discussed postoperative recovery expectations and follow up.
5. Reviewed adjuvant treatment scenarios after surgery.

Time spent face-to-face was 45 minutes and an additional 15 minutes was used to document. Medical decision making was high and complex. A statement including the patient's consent was included in the encounter. Total minutes for the encounter was added to the note.

Diagnosis: C54.1 Endometrial cancer, N95.0 Postmenopausal bleeding, Z71.9 counseling non specified

Final Code: 99204-95 (RVU=3.67), considering adding modifier GT. GT modifier can be added for telehealth platform visits. Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. A -95 modifier is appropriate for Medicare patients who have telehealth visits. The –GT is also a modifier for non-Medicare patients indicative of a telehealth visit.

Prior to the pandemic, telehealth visits were not allowed for new patients and only used for established patients. Due to recent guidelines by CMS, new patient visits are allowed to bill for telehealth services.

Clinical Scenario 4

A 52-year-old *BRCA2* mutation carrier established patient with stage IIIC ovarian cancer on maintenance PARP after upfront chemotherapy presents for a telemedicine encounter. She is called by the office medical assistant 10 minutes before her visit and instructed on how to sign into the patient portal application through her smartphone. The visit pertains to toxicity of the PARP with fatigue and nausea with discussion of surveillance plan and labs.

During this visit the provider and patient did the following:

1. Reviewed PARP dosing with possible dose reduction if symptoms do not improve.
2. Reviewed management of nausea and fatigue with prescription for Zofran and Reglan sent to pharmacy and TSH ordered.
3. Reviewed Lab frequency with new labs ordered monthly for PARP and CA-125 ordered every 3 months.
4. Reviewed signs and symptoms of recurrence and potential indications for CT imaging
5. Reviewed issues related to her goals of treatment, availability of social support at home, ability to accomplish her goals and finally reconsidered her living will, and durable POA.

Time spent face-to-face today was 20 minutes and an additional 10 minutes was used to document. Medical decision making was high and complex. A statement including the patient's consent was included in the encounter. Total minutes for the encounter and documentation after the visit was added to the note.

Diagnosis: C56.1 Ovary Ca, right, C56.2 Ovary Ca, left, Z15.02 BRCA mutation, R53.83 fatigue, unspecified, R11.0 Nausea

Final Code: 99214-GT (RVU= 2.22), considering adding modifier GT. Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. The –GT is a modifier for non-Medicare patients indicative of a telehealth visit.

Clinical Scenario 5

An 85-year-old with newly discovered 6 cm adnexal mass presents for telemedicine encounter. Telemedicine fails. She is called by the office medical assistant 10 minutes before her visit and instructed on how to sign into the patient portal application through her smartphone. The patient is unable to login with her smartphone or computer technology for an audiovisual encounter. The provider calls the patient instead on the phone. Upon establishing audio connection, the provider reviewed with the patient the exact same consent process, identified her and she understood she will receive a charge for services performed. She agreed to this.

During this visit the provider and patient did the following:

1. Discussed the complete history with a 14-point review of systems.
2. Discussed imaging and prior laboratory tests.
3. Reviewed differential diagnosis and management options.
4. Discussed surgical approach, risks, benefits, alternatives and recovery.
5. Obtained verbal consent for surgery.

Time spent face-to-face today was 35 minutes and an additional 15 minutes was used to document. Medical decision making was high and complex. A statement including the patient's consent was included in the encounter. In the documentation of the encounter, the failed attempt at telehealth was noted as was the patient's verbal consent for the encounter. Total minutes for the encounter was documented in the note.

Diagnosis: R19.03 Pelvic mass, right, Z03.89 Observation for suspected malignancy and any other pertinent comorbidities

Final Code: 99204-95 (RVU=3.67). Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. A -95 modifier is appropriate for Medicare patients who have telehealth visits. At this time, CMS will allow for failed telehealth encounters to be billed as telemedicine encounter with specific documentation (attempt for audiovisual connection, verbal consent, and total time for the encounter). This is institutional/practice dependent as well and may change with the landscape of the current pandemic.

Clinical Scenario 6

A 64-year-old with stage IIIC ovarian cancer has postoperative pain and redness near incision 14 days out from surgery. The patient lives two hours away. She presents for a telemedicine visit. With visual technology no drainage or dehiscence is seen. Bactrim is ordered for presumptive wound cellulitis. Precautions upon when to go to the ER or seek medical attention are given. There were15 minutes spent face-to-face and 5 minutes on documentation.

During this visit the provider and patient did the following:

1. Reviewed signs and symptoms of infection, likely wound cellulitis.
2. Discussed pathology and treatment recommendations for chemotherapy.
3. Discussed wound care and starting oral antibiotics.
4. Bactrim sent to pharmacy for patient to start today.

Time spent face—ace today was 20 minutes and an additional 10 minutes was used to document. A statement including the patient's consent was included in the encounter. Total minutes for the encounter was added to the note.

Diagnosis: Cellulitis L03.311, Ovary Ca Right C56.1, Ovary Ca Left C56.2

Final Code: 99024-GT (RVU=2.22). Code 99024 is used because this is a postoperative visit that falls within the 90-day global coverage for surgery. A separate bill collection is not recommended as this does not represent a new process or issue that requires counseling unrelated to the patient's surgery. Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. The –GT is a modifier for non-Medicare patients indicative of a telehealth visit.

Clinical Scenario 7

A 70-year-old established patient sends an inquiry through digital portal discussing her symptoms while on olaparib maintenance therapy. She has recurrent ovary cancer, and has completed 6 cycles of chemotherapy with gemcitabine and carboplatin now almost 12 weeks ago with a partial response. She has been on olaparib for 6 weeks. She was seen 2 weeks ago, and a dose reduction was performed, now to 250 mg orally BID. Dose reduction was in response to severe nausea and anorexia. She reports her symptoms have improved although not fully resolved. She also is reporting fatigue.

In response to her the physician reassures patient and advises continued use of Zofran daily. Option of continued use of medical marijuana was reviewed. Finally, option of use of low dose methylphenidate at 5 mg for fatigue was offered.

In a communication back from the patient, she asks for new prescription for Zofran to be sent to her pharmacy. She wants to try the current dose for additional 2 weeks and will be evaluated in office at that time. In total review of the e-messages, responses, and writing the new prescription took 15 minutes.

Diagnosis: Cáncer of right ovary C56.1, Nausea R11.0, Fatigue R53.83

Final Code: 99422-95 (RVU= 0.72), considering adding modifier GT. The GT modifier can be added for telehealth platform visits. Modifiers are a way to communicate to the payer that the charge is being submitted under special circumstances. The -95 modifier is appropriate for Medicare patients who have telehealth visits. The –GT is also a modifier for non-Medicare patients indicative of a telehealth visit.

E-VISITS: In all types of locations, including the patient's home, and in all areas (not just rural) established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these E-visits, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT

codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services. Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

- 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: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinical Scenario 8

66-year-old female with newly diagnosed stage IVB papillary serous uterine cancer and COVID-19 infection admitted for shortness of breath and bilateral pleural effusions. She was admitted to the ICU and bilateral chest tubes were placed. The initial plan was for palliative chemotherapy once she was medically stable, however, the patient developed rapid disease progression while in the hospital and on hospital day 11 her goals of care were changed to comfort measures only. She had several impediments to discharge to inpatient hospice including the fact that she remained intermittently COVID-19 positive for 48 days. The patient was transferred to the gynecologic oncology service for management of her end-of-life symptoms where she remained for 15 days until she was cleared from COVID-19 infection and could be transferred to a hospice program. Total length of hospitalization 26 days.

During this hospitalization, gynecologic oncology:

1. Provided initial consultation to the ICU team.
2. Discussed initial plans for treatment with the patient.
3. Broke the news about disease progression to the patient in the virtual presence of her family who was off site during the pandemic.
4. Were responsible for 24-hour inpatient coverage, all orders and daily rounding.
5. Held multiple prolonged goals of care discussions with the patient and her family along with palliative care.

Time spent face-to-face via audiovisual communication was 35 minutes on day 1 and an additional 15 minutes was used to document. Medical decision making was high and complex. A statement including the patient's consent was included in the encounter. Total minutes for the encounter was documented in the note daily.

With the gynecologic oncologist in the same building but not in direct contact with the patient, this visit, even though performed via remote audiovisual technology, would still be coded the same as if the attending were in the room with the patient.

1. Place of service 21 is the modifier to denote this encounter took place in the inpatient setting with the provider in the same building. This 2-digit code defines where the service occurs. The case scenario above would still be an inpatient service and not considered telehealth since provider and patient are located in the same building despite use of audiovisual technology

2. POS 02-Place of service for telehealth: This would be the 2-digit code used for services provided by a physician located in a different setting (different building) other than the patient in the hospital via audiovisual technology (e.g. Zoom, Microsoft Teams, Doximity, etc.)
3. If there is no resident/fellow, but rather a video screen that a nurse puts in the room for the attending to perform an audiovisual consultation visit with an inpatient, the billing is the same as above. The provider must ensure for the evaluation and management documented is consistent with what is normally reflected in the CPT codes billed. For example, if billing by components, the provider must ensure the level of billing meets the specifics for that level regarding history, physical exam, and medical decision making or meeting the time requirements if billing based on time regarding total face-to-face time in discussion and what was discussed.

When there is one provider rounding for the primary team, video visits may only be used for subsequent patient ("follow-up") visits and not for initial patient assessments/consults. Consultants/consultation teams may employ video rounding for both initial and subsequent patient visits, under the following circumstances:

1. If it is clinically determined that components of a physical exam can be performed via video or that no physical exam is medically necessary for the patient.
2. If the video visit is not for urgent medical conditions (e.g. chest pain, shortness of breath).
3. If the logistics of the consultation can be managed in a manner acceptable to the primary team, nursing unit, and the consultant.
4. House staff performing an inpatient video visit must be supervised by an attending physician. Supervising physicians will direct the care of the patient and provide the appropriate level of supervision based on the complexity of care and the experience, judgment and level of training of the house staff being supervised. The supervising attending may select and employ the modality of supervision (Zoom, Microsoft Teams, etc.)

At all times, it is the responsibility of the physician seeking to perform the video visit to determine, within his/her clinical judgment and prior experience, whether an adequate exam can be achieved via video with that patient at that time. If the conclusion is that an adequate exam cannot be achieved, it is the obligation of that physician to make alternative arrangements that address the clinical circumstance including the following:

1. Seeing the patient face-to-face.
2. Making another effort to perform an audiovisual visit at a later time.
3. Reviewing the chart and discussing the case with the primary team, to evaluate whether the consultant recommendations can be safely and adequately provided in the absence of an in person or video visit.

Depending on type of service the physician is providing, the codes remain the same regardless of in person or telehealth: Initial hospital consultation for non-Medicare patients: 99251-99255, Initial hospital care 99221-99223, Subsequent Hospital Care 99231-99233

Diagnosis: C54.1 Endometrial cancer, U07.1 COVID-19 virus identified

Final Code: Day 1 99222 (place of service-21) (RVU=3.87) , subsequent days 99231(place of service -21) (RVU= 1.11). Place of service 21 is the modifier to denote this encounter took place in the inpatient setting with the provider in the same building. This 2-digit code defines where the service is rendered. The case scenario above would still be an inpatient service and not considered telehealth since provider and patient are located in the same building despite use of audiovisual technology. POS 02-Place of service for telehealth:

This would be the 2-digit code used for services provided by a physician located in a different setting (different building) other than the patient in the hospital via audiovisual technology (e.g. Zoom, Microsoft Teams, Doximity, etc.)

RVU values (this may vary depending on your institution and use of modifiers)

RVUs are the basic component of the Resource-Based Relative Value Scale (RBRVS), which is a methodology used by the Centers for Medicare & Medicaid Services (CMS) and private payers to determine physician payment. RVUs define the value of a service or procedure relative to all services and procedures. RVUs determine physician compensation when the conversion factor (CF), dollars per RVU, is applied to the total RVU. Under the RBRVS, physician payment for services are determined by the following: 1) total RVUs, 2) Geographical Practice Cost Indices (GPCIs), and Conversion Factor (CF).

Outpatient Office Visit Established Patient Level 1 (99211) RVU 0.18

Outpatient Office Visit Established Patient Level 2 (99212) RVU 0.48

Outpatient Office Visit Established Patient Level 3 (99213) RVU 0.97

Outpatient Office Visit Established Patient Level 4 (99214) RVU 1.50

Outpatient Office Visit Established Patient Level 5 (99215) RVU 2.11

Telehealth Outpatient Office Visit Established Patient Level 2 (99212-95) RVU 0.48

Telehealth Outpatient Office Visit Established Patient Level 3 (99213-95) RVU 0.97

Telehealth Outpatient Office Visit Established Patient Level 4 (99214-95) RVU 1.50

Telehealth Outpatient Office Visit Established Patient Level 5 (99215-95) RVU 2.11

Telehealth Outpatient Office Visit New Patient Level 3 (99203-95) RVU 1.42

Telehealth Outpatient Office Visit New Patient Level 4 (99204-95) RVU 2.43

Postoperative Follow Up visit (99024) RVU 0.00

Outpatient Office Consultation Level 4 (99244) RVU 3.02

Telehealth Outpatient Consultation Level 4 (99244-95) RVU 3.02

Outpatient Office New Patient Level 3 (99203) RVU 1.42

Outpatient Office New Patient Level 4 (99204) RVU 2.43

Outpatient Office New Patient Level 5 (99205) RVU 3.17

Telehealth Outpatient Office New Patient Level 3 (99203-95) RVU 1.42

Telehealth Outpatient Office New Patient Level 4 (99204-95) RVU 2.43

Telehealth Outpatient Office New Patient Level 5 (99205-95) RVU 3.17

Initial Inpatient Hospital Care Level 1 (99221) RVU 1.92

Subsequent Inpatient Hospital Care Level 1 (99231-GC) RVU 0.76

Initial Inpatient Hospital Care Level 2 (99222) RVU 2.61

Physician Telephone Evaluation 5-10 min 99441, G2012 RVU 0.48

Physician Telephone Evaluation 11-20 min 99442, G2012 RVU 0.97

Resources:

1. **SGO Telemedicine for Gynecologic Oncology Care During the Covid-19 Pandemic**
2. **SGO Coding Corner with Dr. David Holtz, MD**
3. **Medicare Telehealth Frequently Asked Questions**
4. **Medicare Telemedicine Health Care Provider Fact Sheet**
5. **From Dr. Shitanshu Uppal FaceTime or WhatsApp: How to implement video calls using FaceTime**
6. **AMA Quick Guide for Telemedicine**