INTRODUCTION

With the initial COVID-19 outbreak, CMS and all states implemented a number of regulations and policies that called for hospitals, physicians, dentists and other healthcare providers to minimize, postpone and cancel elective, non-urgent procedures.

Doing so reduced the burden on the healthcare system as the nation responded to the pandemic and practiced social distancing. During this time, CMS and states eliminated previously placed barriers to telehealth use – including telephone or virtual evaluations and/or treatment advice – to help patients access care remotely and reduce the strain on hospitals and clinics.

As states begin to ease their restrictions on elective and non-urgent care, telehealth services are likely to remain a staple in the delivery of healthcare due to its convenience and efficiency with providing flexibility for assessing further treatment.

This coding paper provides guidance on the various modes of conducting telehealth services, including CPT and CDT coding options. AAOMS advises OMSs to refer to the CPT and CDT coding books and guidance published by the AMA and ADA for complete coding guidelines. Coverage policies and billing procedures related to telehealth services vary among payers. Therefore, OMSs are encouraged to confirm benefits and billing protocols with each payer prior to submitting claims and review managed care contract terms prior to balance billing patients. Lastly, the ability for an OMS to perform telehealth services varies by state. Therefore, it is each OMS’s responsibility to confirm such services are within the scope of his or her license(s) as directed by the state Dental Practice Act and/ or state Medical Practice Act.

DEFINITION

The Department of Health and Human Services (HHS) defines telehealth as the use of electronic information and telecommunication technologies to extend care when a patient and doctor are not in the same place at the same time.

Telemedicine is the practice of medicine using technology to deliver care at a distance and, similarly, teledentistry is the use of information technology and telecommunications for dental care, consultation, education, public awareness and communication between dental or medical providers regarding care of a mutual patient.

Indications in the SARS-CoV-2/COVID-19 environment:
• Reduce office traffic
• Patient convenience
• At-risk patients: insulin-dependent diabetes mellitus, obesity, immunosuppression, pulmonary disease
• Postoperative visits for routine, minimally invasive procedures
• Screening consults

HOW TELEHEALTH IS RENDERED

Both teledentistry and telemedicine may be rendered via video, audio or virtual check-in using a phone or device with internet. Modes are often referred to as synchronous or asynchronous:
• Live video chat (synchronous) – live, two-way interaction between a person (patient, caregiver or provider) and a provider using audiovisual telecommunications technology.
• Store-and-forward (asynchronous) – transmission of radiographs, photographs, video or digital impressions through a secure electronic communications system to a practitioner. This information is then used to diagnose or provide a service.
• **Remote patient monitoring (RPM)** – collecting personal health and medical data from a single individual via electronic medical device technologies. The data are transmitted to a different location (sometimes via a data processing service) where the provider can access the data for monitoring conditions and supporting care delivery.

• **Mobile health (mHealth)** – healthcare education, practice and delivery done over mobile communication devices, such as cellphones, tablet computers and personal digital assistants (PDAs).

As a result of the COVID-19 pandemic, HHS has deemed applications such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, WhatsApp video chat, Zoom and Skype as acceptable services of communication for telehealth. However, HHS advised that public-facing apps – such as Facebook Live, Twitch and TikTok – should not be used in the provision of telehealth by covered healthcare providers.

Currently, AAOMS does not offer a telehealth service recommendation. However, OMSs may wish to follow up with their own software vendor, which may have the capability to conduct telehealth services. OMSVision, for example, has recently reported adding a telehealth feature to its software.

Questions to consider when using software: How is PHI protected? What equipment is needed? Is there a waiting room feature? Does the software allow for scheduling appointments and obtaining consent? Will the patient need to download an application or software to utilize the service?

**What services may be rendered via telehealth**

Telehealth may prove to be an efficient method to triage patients to determine if their condition is urgent or emergent and warrants an in-person visit. It also can be useful for when providing a quick check-in or for conducting a postoperative visit.

Some OMSs have reported they are seeing initial consultations for single-tooth extractions, biopsy pre-ops and non-complicated third molar cases when an adequate radiograph is provided by the referring dentist. The OMS workflow during such telehealth visits may include pre-op instructions, risks, benefits, treatment alternatives and scheduling.

These telehealth visits may be conducted over the phone, digitally via face-to-face or even interprofessionally. CMS has published an expanded list of telehealth services payable under the Medicare Physician Fee Schedule during the pandemic. It is recommended to contact commercial payers to verify what services they are currently covering via telehealth.

**Consent for treatment via telehealth**

The OMS is still expected to obtain a patient’s consent for conducting services via telehealth. Some practices are utilizing patient portals within their EHRs, email or options such as DocuSign to have patients sign all consent forms virtually. If the patient is treated in the office and the follow-up visit is scheduled to be rendered via telehealth, it is best to have the patient sign the consent when he or she is in the office.

**Limited HIPAA waivers**

The Office for Civil Rights at HHS offered limited waivers of HIPAA sanctions and penalties during the national health emergency to lift privacy barriers associated with telehealth services, in particular, using video chat apps as previously mentioned. The Project BioShield Act of 2004 (PL 108-276) and section 1135(b)(7) of the Social Security Act waivers are in effect until a federal government declaration that the SARS-CoV-2/COVID-19 healthcare emergency is over. Following declaration of the end of the pandemic, it is expected the waivers will be withdrawn, and guidance from the federal government will be expected:

- **Limited Waivers of HIPAA Sanctions and Penalties**
- **Notification of Enforcement Discretion for Telehealth Remote Communications**

**CODING/DOCUMENTATION FOR TELEHEALTH SERVICES**

Several CPT and CDT codes may be reported for conducting virtual evaluations and/or treatment advice to patients.
It is imperative to review the complete coding guidance in CPT and CDT coding books prior to using these codes because of their specific guidelines. Both the AMA and ADA continue to issue coding guidance for use of telehealth codes, including practice implementation tips, coverage and policy summaries, and example coding scenarios.

It also is imperative the mode of telehealth used is documented, including the duration of the telehealth visit. In some instances, payers will allow coverage for traditional evaluations rendered via telehealth. However, keep in mind the components/criteria of these typical evaluations must still be met; therefore, documentation must support the service reported and billed.

**TELEDENTISTRY CODING**

If OMSs see a patient in their office during the current COVID-19 pandemic, the services they render in the office should be coded and billed as they typically would if rendered in the office.

For services rendered using telecommunication technology to triage patients or to determine if the situation is urgent or emergent, the following CDT codes may be used to document and report:

- **D0140** limited oral evaluation – problem focused
- **D0170** re-evaluation – limited, problem focused (established patient; not postoperative visit)
- **D0171** re-evaluation – postoperative office visit
- **D0190** screening of a patient
- **D0191** assessment of a patient
- **D9992** dental case management – care coordination
- **D9995** teledentistry – synchronous; real-time encounter
  - Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service
- **D9996** teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review
  - Reported in addition to other procedures (e.g., diagnostic) delivered to the patient on the date of service

**Sample scenarios**

| OMS provides a consultation to a patient using audio means only | D0190 or D0999 |
| OMS provides a problem-focused evaluation using audio and visual means | D0140 or D0170 or D0171 and D9995 or D9996 |
| Triage call center forwards a patient to an OMS who provides a problem-focused evaluation using audio and visual means | Call Center: D0190 or D0999 OMS: D0140 or D0170 or D0171 and D9995 or D9996 |
| General dentist or OMS forwards a patient to a different specialist who provides a problem focused evaluation using audio and visual means | General dentist/OMS: D0190 or D0999 Specialist: D0140 or D0170 or D0171 and D9995 or D9996 |

**TELEMEDICINE CODING**

CMS recognizes three types of virtual medical services: telehealth visits, virtual check-ins and e-visits. Telehealth (telemedicine) visits are visits between a physician and a patient using telecommunication systems. Virtual check-ins are brief check-ins (less than 10 minutes) with a patient via the phone or other telecommunication device to determine whether an office visit is needed. E-visits are conducted through an online patient portal and are initiated by the patient. CMS advises that during this health emergency, telemedicine visits may be billed using standard E/M codes with the place of service (POS) code 11 (office) along with the modifier – 95 to allow CMS to ensure payment parity for these services. Commercial medical payers may have their own individual billing rules with regards to POS and modifiers; therefore, it is advised to confirm each payer’s preference prior to submitting claims.
As stated, when selecting the appropriate code for the telemedicine service, it is imperative the OMS documents the mode utilized as well as the duration of the telehealth service. It also is important to keep in mind the requirements for selecting and reporting a traditional E/M code via telemedicine is the same as required for in-person evaluations. Per the AMA, “if you determine the level of service by elements of history, exam, and medical decision making, then a full clinical review of systems performed and documented is required. If you determine the level of service by time, no such review is required.”

The AMA provides an extensive list of FAQs related to telemedicine services. If the visit does not meet the components of a traditional evaluation and management service, the following codes may apply. However, CPT guidelines restrict the use if a face-to-face visit had taken place or will take place within a certain number of days of the telehealth visit. AAOMS strongly recommends reviewing the complete CPT guidelines in the CPT book prior to using these codes:

**Telephone services (99441-99443)** – These are non-face-to-face E/M services provided to a patient using the telephone when initiated by an established patient. Per CPT coding guidelines, if the telephone service ends with a decision to see the patient within 24 hours or at the next urgent care appointment, it is not to be reported as the encounter is considered part of the preservice work of the subsequent E/M service. It also is not to be reported if the telephone service is related to an E/M service seven days prior or within the postoperative period of a previously completed procedure as it is then considered part of that previous E/M service.

**Time by Code:**
- 99441: 5-10 minutes of medical discussion
- 99442: 11-20 minutes of medical discussion
- 99443: 21+ minutes of medical discussion

Appendix P in the CPT coding book includes a list of codes for synchronous telemedicine services. They also are marked with a star in the tabular list.

**Online digital E/M services (e-visits) (99421-99423 or G2010/G2012 if billing Medicare or preferred by the payer)** – These CPT codes took effect Jan. 1, 2020, and may be used when rendering a digital evaluation for an established patient who initiated the digital evaluation by sending the OMS a message detailing his or her concerns via a patient portal, secure email or other electronic communication that is HIPAA-compliant. These services are not for the nonevaluative electronic communication of test results, scheduling of appointments or other communication that does not involve an E/M. These codes may only be reported once for the doctor’s cumulative time over a seven-day period.

**Time by Code:**
- 99421: 5-10 minutes
- 99422: 11-20 minutes
- 99423: 21+ minutes

**Interprofessional telephone/internet/electronic health record consultations (99446-99452)** – These represent an assessment and management service in which the patient’s treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist the treating physician or other qualified healthcare professional in the diagnosis and/or management of the patient’s problem without face-to-face contact with the consultant. The patient for whom these interprofessional consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. These codes also may not be reported if these interprofessional consultations lead to a transfer of care or other face-to-face service within the next 14 days or next available appointment date of the consultant.

**Time by Code:**
- 99446: 5-10 minutes of medical consultative discussion and review
- 99447: 11-20 minutes of medical consultative discussion and review
- 99448: 21-30 minutes of medical consultative discussion and review
99449: 31 minutes or more of medical consultative discussion and review
99451: 5 minutes or more of consultative time
99452: 30 minutes

Sample scenario for “synchronous” telemedicine visit via video

Use the same codes for face-to-face E/M visits along with appending modifier GT or – 95:
1. 99211-99215 for established patients
or
2. 99201-99205 for new patients

Modifier – 95 – synchronous telemedicine service rendered via real-time

Modifier GT – via interactive audio and video telecommunication systems

Check with the individual payer for its specific policies and guidelines and codes for which modifier – 95 assignment is applicable. Some payers may require modifier GT as an alternative. Some payers also may require a specific POS and modifier assignment to the claim. Some commercial payers are requiring the telehealth POS-02 with modifier – 95, whereas others are allowing the POS where the visit would have occurred under normal circumstances.

Matters to discuss with patients regarding the use of a teleconferencing platform:

• Confirm the patient has used videoconferencing before and, if not, offer a practice meeting with a staff member.
• Provide instructions/tips to the patient (be alone if privacy is preferred, good lighting, functional microphone and speakers, retraction available, reliable internet connection, etc.).
• Discuss how long should be allotted for a teledentistry appointment.
• Notify if other staff members will participate in the teleconference.
• What must be done prior to the meeting (online registration, insurance breakdown, referral received, consent, etc.).
• Notify whether the teleconference will be recorded by the provider or the patient.
• Inform of use of a digital background (Zoom).

• Discuss how consent will be obtained.
• Create an email template to include patient education materials, telehealth consent, COVID-19 information, etc., along with the videoconference invitation link (unless a website-based platform will be used).
• Notify of when will patients be informed of the charges associated with the telehealth consult and will they be charged for the in-person exam.
• Discuss what occurs if the insurance does not pay for the telehealth consult.
• Discuss what is the plan if there are technical problems during or preventing the scheduled telehealth consultation.

SAMPLE DOCUMENTATION

Document the following:

• Clearly state communication was via telecommunication
• The platform used: Zoom, BlueJeans, MouthWatch
• The method of telecommunication:
  • Audio only
  • Audio and video
• Patient consent (dated)
• Whether recording of the conversation is not authorized
• Date and time of service
• Reason for the appointment
• Chief complaint
• PMH/ROS review
• Synopsis of visual findings
• Assessment
• Plan:
  • Labs, orders, radiology
  • Referrals
  • Follow-up
• Documentation of the time spent on the call
PAYER COVERAGE

Coverage and reimbursement may vary among insurance carriers. Some insurance carriers are temporarily waiving copays and deductibles for telehealth services rendered during the national health emergency, while others are waiving the need for prior authorization. Some plans will only cover the costs of diagnostic testing and/or services related only to COVID-19.

While CMS lifted restrictions on the originating site of the telehealth service, some commercial payers may still apply limitations as to the originating site of the telehealth service, so the patient’s benefit language and/or the carrier’s coverage criteria will need to be reviewed to determine coverage.

Provider contracts also may be reviewed to determine whether the patient may be billed in the event it is denied. Lastly, state laws concerning carrying out telehealth and teledentistry may vary, so confirm with state dental and medical boards to determine if/when appropriate to render telehealth services in the practice.

Sample payer policies:

- **CMS coverage** – On April 30, CMS issued a second interim final rule expanding telehealth visits to phone calls. Providers can now be reimbursed for phone calls at the E/M office/outpatient rates by reporting 99441-99443 along with modifier – 95 and the POS in which the service would normally be furnished. OMSs should follow up with their payers to determine if a similar benefit will be considered.

- **America’s Health Insurance Plans** has been tracking the policies from many major medical payers.

- **The ADA** has been tracking the response from many major dental payers.

ADDITIONAL RECOMMENDATIONS

Consult with a liability carrier regarding telemedicine consent forms and additional documentation required for a telemedicine/telehealth/teledentistry consultation. The OMS National Insurance Company (OMSNIC) has released a series of FAQs on its website.

AAOMS also published the AAOMS White Paper on Telehealth and Remote Treatment in January 2020.

Note: This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

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This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses procedural coding guidelines utilizing CPT, HCPCS and CDT. When indicated, reference the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.


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