

Colorado Rural Health Center Provider Education Session – COVID-19 Telehealth CMS Updates

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Telehealth Services

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COVID-19 State-of-Play: Regulatory, Legislative

Congress

- LAW: March 6: COVID-19 funding package #1, Coronavirus Preparedness and Response Supplemental Act (P.L. 116-123), enacted
 - Includes telehealth change
- LAW: March 18: COVID-19 funding package #2, Families First Coronavirus Response Act (P.L. 116-125), enacted
 - Include telehealth change
- LAW: March 27: COVID-19 funding package #3, Coronavirus Aid, Relief, and Economic Security Act (CARES Act): \$2+ trillion dollar economic stimulus package, enacted

Administration

- March 13: President declares COVID-19 a national emergency
- March 13: CMS announces various 1135 waivers (now allowed because of declaration of emergency)
- March 17: CMS releases telehealth flexibility, guidance
- March 27 and 31st: CMS releases additional telehealth flexibility and guidance especially for RHCs and FQHCs





Understanding Medicare's Reimbursement Pre-COVID-19

Telehealth

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Medicare: Telehealth \neq Virtual Health

What requirements exist/ed before COVID-19?

- Under Medicare statutes and regulations, “telehealth” is had a complicated regulatory construct
- General requirements for being able to use and be reimbursed for telehealth include:
 - Beneficiary is at approved “originating site” setting (hospital, clinic etc) in approved rural areas
 - Only certain practitioners can provide services and be reimbursed (physicians etc)
 - Only approved codes are reimbursed - In other words, not all Medicare services are reimbursable if done via telehealth
 - Service must be done in an approved manner. In other words the modality must be “real-time” audio/video (called “synchronous”)



Looking Deeper: Medicare “Telehealth” Regulations

Telehealth reimbursement began as a means to expand access in rural areas and was driven by Medicare. Under Medicare, only specific services performed by specific providers at specific locations are covered.

- “Originating site” requirements (where patient is located for services)
 - An acceptable site where tele-capability exists and in rural area:
 - ◇ A county outside of a Metropolitan Statistical Area (MSA) or
 - ◇ A rural Health Professional Shortage Area (HPSA) located in a rural census tract
- “Distant site” requirement
 - Where the *practitioner* is who will provide the service/bill for the service
 - Only certain providers are acceptable under distant site requirements
- Store & Forward not covered, must be real-time audio/video (synchronous) technology (except for Hawaii, Alaska)



Looking Deeper: Qualifying Originating Sites

- Offices of physicians or practitioners
- Hospitals, Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs) and
- Community Mental Health Centers (CMHCs)

Are you located in a rural area that qualifies?

<https://datawarehouse.hrsa.gov/tools/analyzers/geo/Telehealth.aspx>



Qualifying Distant Site Practitioner

- Physicians
- Nurse practitioners (NPs)
- Physician assistants (PAs)
- Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs) and clinical social workers (CSWs).
 - *CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services.*
- Registered dietitians or nutrition professionals

(all subject to respective State law)



Reimbursable Services

Medicare reimburses for a specific list of services/codes. While CMS continues to expand this list every year, services generally fall into the following areas:

- Behavioral health
- Chronic disease management
- Professional consultations
- End stage renal disease
- Wellness services

Telehealth Services		MLN Booklet	
CY 2018 Medicare Telehealth Services		CY 2018 Medicare Telehealth Services (cont.)	
Service	HCPSC/MPT Code	Service	HCPSC/MPT Code
Telehealth consultations, emergency department		End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of dialysis, assessment of growth and development, and counseling of parents	CPT code 90965
Follow-up inpatient telehealth consultations for beneficiaries in hospitals or SNFs		End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	CPT code 90966
Office or other outpatient visits		End-Stage Renal Disease (ESRD)-related services for home dialysis per full month of service, per day, for patients younger than 2 years of age (effective for services furnished on and after January 1, 2017)	CPT code 90967
Subsequent hospital care services, with the 1 telehealth visit every 3 days		End-Stage Renal Disease (ESRD)-related services for home dialysis per full month of service, per day, for or services furnished	CPT code 90968
Subsequent nursing facility care services, with limitation of 1 telehealth visit every 30 days		End-Stage Renal Disease (ESRD)-related services for home dialysis per full month of service, per day, for or services furnished	CPT code 90969
Individual and group kidney disease education			
CY 2018 Medicare Telehealth Services (cont.)		CY 2018 Medicare Telehealth Services (cont.)	
Service	HCPSC/MPT Code	Service	HCPSC/MPT Code
Annual depression screening, 15 minutes	HCPSC code 92044	Extended services in the inpatient or observation setting (beyond the usual service, each additional 30 minutes first separately in addition to code for prolonged service)	CPT code 90970
High intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior, performed semi-annually, 30 minutes	HCPSC code 90971	Annual Wellness Visit, includes a personalized prevention plan of services (PPSP), patient or proxy	HCPSC code 90972
Annual, face-to-face interactive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPSC code 90973	Annual Wellness Visit, includes a personalized prevention plan of services (PPSP), subsequent visit	HCPSC code 90973
Face-to-face behavioral counseling for obesity, 15 minutes	HCPSC code 90974	Annual Wellness Visit, includes a personalized prevention plan of services (PPSP), subsequent visit	HCPSC code 90974
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99450	Telehealth Consultation, Critical Care, initial, physician (typically spend 60 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017))	HCPSC code 90980
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99451	Telehealth Consultation, Critical Care, subsequent, physician (typically spend 30 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017))	HCPSC code 90981
Advance Care Planning, 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99452	Consulting visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (includes the eligibility determination and shared decision making (effective for services furnished on and after January 1, 2018))	HCPSC code 90982
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99453	Interactive Complexities, Psychiatry Services and Procedures (effective for services furnished on and after January 1, 2018)	CPT code 90983
Psychoanalysis	CPT code 90984	Health Risk Assessment (effective for services furnished on and after January 1, 2018)	CPT code 90984
Family psychotherapy (without the patient present)	CPT code 90985	Comprehensive assessment of and care planning for patients requiring chronic care management (effective for services furnished on and after January 1, 2018)	HCPSC code 90985
Family psychotherapy (except psychotherapy) (with patient present)	CPT code 90986	Psychotherapy for adults (effective for services furnished on and after January 1, 2018)	CPT code 90986
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	CPT code 90987		
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes	CPT code 90988		
Prolonged service in the inpatient or observation setting requiring direct patient contact beyond the usual service, first hour (first separately in addition to code for inpatient evaluation and management service)	CPT code 90989		
Prolonged service in the inpatient or observation setting requiring direct patient contact beyond the usual service, each additional 30 minutes	CPT code 90990		

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For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" visit (not telehealth) each month to ensure the vascular access code.

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Medicare Fee-For-Service Only

- Keep in mind, what we've discussed so far applies only to Medicare FFS
- States can determine their own telehealth reimbursements, requirements
 - Licensing is uniquely state-specific and impacts telehealth that may cross state lines
- Medicare Advantage can function differently as well





Understanding Medicare's Reimbursement Post-COVID-19

Telehealth

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Key Resources, Source Documents

- CLA is on the frontlines and closely monitoring and analyzing activities related to telehealth and other virtual health regulations
 - Stay tuned to CLA's COVID-19 resource page, <https://www.claconnect.com/topics/coronavirus#Resources> and CLA's Health Care Innovation & Insight blog, <https://blogs.claconnect.com/healthcareinnovation/>, for ongoing updates
- CMS telehealth fact sheet, Frequently Ask Questions
 - <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
 - <https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>
 - https://www.cms.gov/files/document/covid-final-ifc.pdf?fbclid=IwAR1_jhW_cnz_o8QmrWv5-QuskdfyIR6Z0GDtw1YV89glkJHNsYvGfdk7upl



Broad Overview of New Guidance

In an effort to remove regulatory barriers to telehealth and assist with social distancing during the pandemic, CMS released guidance providing telehealth flexibility, **effective March 6, 2020**.

- Beneficiaries do not need to be located in a rural area or at an approved “originating site.” Instead, the waiver allows telehealth services in the home or any setting of care.
- Health care providers are not required to have an established relationship with a patient. Specifically on this point, CMS states that to the extent there is that requirement, “HHS will not conduct audits” on claims during this crisis.
- CMS will allow the use of telephones that have audio and video capabilities (like FaceTime or Skype) for furnishing services. In doing so, HIPAA penalties will be waived when using these and when serving patients in good faith.
- Providers are allowed to use and be reimbursed for services even if those are not related to COVID-19 diagnosis.



Some More Details

- Originating sites
 - No longer need to be in a rural location
 - Home or other health care settings are acceptable
- Distant site practitioners
 - New guidance does not change the list of acceptable providers
- Modality
 - New guidance does not change the type of modality (still must be synchronous) but does allow for use of Skype, FaceTime etc to visit with patients
 - ◇ The new waiver authorizes telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/index.html>



Pre-Existing Relationship

- The two COVID-19 funding packages included telehealth flexibility but left in some statutory language that may require a pre-existing relationship
- With the 1135 waiver authority (due to President declared emergency), the Department of Health and Human Services (HHS) states that a pre-existing relationship is not required, and to the extent that there would be this requirement, the new HHS guidance states that, “HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency”
- In other words, the patient does not have to be an established patient in order for the patient to be seen in a telehealth scenario
 - This is only temporary during the COVID-19 crisis



Billing, Coding, Documenting

- Reimbursable Codes
 - The waiver guidance does not appear to change the list of codes that can be reimbursed if done via telehealth (though CLA believes the language is confusing)
 - Therefore, codes that may be billed are limited to the codes listed at:
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
 - The guidance indicates these codes/services do not have to be connected to COVID-19 diagnosis, however
 - Reimbursement will be the same as an in-person visit but at facility rate
- Coding use telehealth Place of Service code – 02 (zero two), no modifier for Medicare claims and reimbursed at facility rate
- Normal documentation for whatever service is being billed
- Guidance allows for providers to waive the patient's costsharing as well as providing Medicare Advantage/Part D plans additional flexibility
 - <https://www.cms.gov/newsroom/press-releases/cms-issues-guidance-help-medicare-advantage-and-part-d-plans-respond-covid-19>



Update March 30, 2020

<https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

- Additional services added to telehealth list – but **only** during PHE
- New guidance on place of service and modifiers
- Medicare will now cover telephone calls 99441-99443
- Consent required but may be obtained annually and may be obtained by ancillary staff
- For services requiring direct supervision, this supervision may be provided with real-time interactive audiovisual technology
- Residents may perform telehealth with real-time supervision through interactive telecommunications technology



Temporary Guidance for Medicare Telehealth

Medicare Telehealth – Interim Final Rule

“On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule. It remains our expectation that practitioners will document E/M visits as necessary to ensure quality and continuity of care. To reduce the potential for confusion, we are maintaining the current definition of MDM. We note that currently there are typical times associated with the office/outpatient E/Ms, and we are finalizing those times as what should be met for purposes of level selection.” p. 136



AMA Quick Guide Telemedicine Practice

- Double check payer guidance as AMA may be more general than actual payers
- <https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice>



AAFP Guidance for Telehealth in light of COVID-19

- <https://www.aafp.org/patient-care/emergency/2019-coronavirus/COVID-19-daily/telehealth.html>
- Health care providers must still comply with state telehealth laws and regulations, including professional licensure, scope of practice, standard of care, [patient consent\(www.cchpca.org\)](http://www.cchpca.org), as well as other payment requirements for non-Medicare beneficiaries.
- Many payers are requiring modifiers GT, GQ or 95 depending upon service being performed – telehealth, virtual care, e-visits

Interstate Licensure → Open Question

HHS waiver and comments from the Administration indicate that CMS is waiving the requirement for providers to be licensed in the states where they may provide telehealth services. There are questions on what this means, how this could actually occur. We await additional guidance from CMS.



Controlled Substances

As part of the 1135 waiver, controlled substances may be prescribed through telehealth if:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.



Telehealth – Prescribing Controlled Substances - Resources

- <https://www.deadiversion.usdoj.gov/coronavirus.html>
- <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>



Teaching Physician Considerations

New guidance during PHE –

- Supervision of E&M services can be through telecommunications
- Primary Care Exception will apply to all levels of E&M
- Surgery and anesthesia will still require physical presence during key portions
- Radiology and other diagnostic services will still require that Teaching Physician view images/specimens
- Resident may furnish telehealth services with supervision of Teaching Physician by telecommunications
- Resident may moonlight in the same hospital as GME if with different service



To Ensure Success!

- Follow the guidelines from each payer – don't assume that they are the same as CMS.
- Documentation should fulfill the requirements of the code billed.
- Diagnosis should be documented at each encounter.
- Store the encounter information where it is accessible for provider and for payer review.



Dates of Importance

- Telehealth waiver flexibility is retroactive to March 6, 2020
- The telehealth waiver ENDS when the public health emergency ends
- The Temporary E/M Time for Telehealth will also end when the PHE ends
- Other CARES Act signed 3/27/2020 – CMS Rule issued 3/31/2020
- Coding guidance is valid as of 3/31/2020



Co-Pay Waiver – Information from OIG

– Released March 24, 2020

- 1. Question: Does the Policy Statement apply to services provided remotely through information or communication technology, or is the Policy Statement limited to the specific services the Centers for Medicare & Medicaid Services (CMS) refers to as “telehealth visits”?
- Answer: OIG’s Policy Statement is not limited to the services governed by 42 C.F.R. § 410.78 and referred to by CMS as “telehealth visits.” OIG intends for the Policy Statement to apply to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring
- <https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/telehealth-waiver-faq-2020.pdf>



Co-Pay Waiver – Information from OIG

– Released March 24, 2020

- 2. Question: Many physicians and other practitioners are organized within larger healthcare provider entities and systems. Does the Policy Statement apply to a hospital, for example, when a physician or other practitioner who has reassigned his or her right to receive payments to the hospital provides services remotely through information or communication technology?
- Answer: The Policy Statement applies to a physician or other practitioner billing for services provided remotely through information or communication technology or a hospital or other eligible individual or entity billing on behalf of the physician or practitioner for such services when the physician or other practitioner has reassigned his or her right to receive payments to such individual or entity





Understanding Medicare's Reimbursement for Other Virtual Health Care

E-Visits, Virtual Health, Remote Patient Monitoring

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Key Notes and Toolkit

- HHS has not defined the following as “telehealth”, therefore, the previous guidance we’ve discussed and telehealth requirements do not apply:
 - E-visits
 - Interprofessional consultations
 - Remote patient monitoring
 - Virtual check-in
- These items continue to be reimbursed like they were before the COVID-19 guidance and can be used once the emergency ends
- New toolkit was released from CMS on 3/20/2020 -
- <https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>



Modifiers

95 - Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System (CMS discontinued requirement for this modifier when POS 02 was created.)

GQ - Via asynchronous telecommunications system (Alaska and Hawaii only)

GT - Via interactive audio and video telecommunication systems

G0 - Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

CMS has stated that a modifier is not necessary when using POS 02, but many contractors and payers are requesting the use of:

CR - Catastrophe/disaster related



Office Visit Coding

Question raised about doing examinations where the physician cannot “lay hands” on the patient -

Consider –

- Established patient office visit codes require 2 out of 3 key components: History, Examination, Medical Decision-Making
- Some examination can be performed through observation or conversation;
- For example:
 - general appearance
 - sclera anicteric injected
 - hearing intact
 - skin tone
 - respiratory effort
 - gait and station
 - mental status.



Telephone Calls

March 30, 2020 – CMS announced Medicare coverage of these codes ***during this PHE only!***

- 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 \$14.44
- 99442 - 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; 11-20 minutes of medical discussion \$28.15
- 99443 - 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; 21-30 minutes of medical discussion \$41.14



Telephone Calls – Other Non-Physician Professionals

- 98966 - Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 98967 - Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
- 98968 - Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion



Medicare Telehealth Example

Patient is concerned that her blood sugar is running higher than usual. She contacts her physician who responds by Skype, questions her about any changes in diet, exercise, etc. and advises her on changes to her medication.

- Expanded Problem-Focused History (Severity, Modifying Factors plus a limited Review of Systems)
- Problem-Focused Examination (General Appearance)
- Low Complexity Medical Decision-Making (1 Established Problem – Worsening, Medication Management)

99213

Be sure to document the diagnosis treated and any coexisting conditions that affect care.



Hospitals and Nursing Facility Telehealth

- Subsequent care has been on the telehealth list – initial care added during the PHE
- Like other telehealth services, requires an audio AND video link with ***the patient***
- Talking with the nursing staff would not qualify as telehealth
- Consulting with other physicians, without seeing the patient, may meet the parameters for interprofessional consultation



TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	<p>Common telehealth services include:</p> <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) <p>For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</p>	<p>For new* or established patients.</p> <p>*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency</p>
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	<ul style="list-style-type: none"> • HCPCS code G2012 • HCPCS code G2010 	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2062 • G2063 	For established patients.



Medicare Telehealth

- Even during PHE, requires real-time audio AND video link
- Only applicable for services on the list at:
<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

updated March 30, 2020

- The criteria for the code must still be met.

Previous guidance from CMS – POS 02 resulted in payment at the Facility rate.

New guidance – provider can choose to use whichever POS is most appropriate with modifier 95.

Other services now payable such as virtual check-in, online services, and telephone calls are not considered telehealth.



Online digital evaluation & management

- If the visit is not real-time audio and video, then use HCPCS code G2012 or the new 99421-99423 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 - 11-20 minutes
 - #99423 - 21 or more minutes
-
- Patient must be an established patient, not limited to settings
 - *Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication*
 - Rural Health Clinics and Federally Qualified Health Centers may be paid for these outside the encounter rate using new code G0071



Online digital evaluation & management continued

- *99421-99423 require* physician or other QHP's evaluation, assessment, and management of the patient by the provider
- These services are not for the nonevaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M



FQHC/RHC Telehealth

- The CARES Act was signed on 3/27/2020 which allowed the FQHCs and RHCs to be distant sites – waiting to have guidance as to how these services for Telehealth can be billed for these facilities
- In the meantime, CMS HAS approved payment for the following services for these facilities:
 - Telephone calls 99441-99443 (Nonphysician professionals – 98966-98968)
 - G0071 – Payment has been increased to
 - **As of 4/3/2020 – there are no payment guidelines as to how these claims are to be submitted nor paid by CMS**



FQHC/RHC

FQHCs and RHCs were approved as distant sites for Medicare telehealth per the CARES Act

- May perform Virtual Check-In and bill G0071

G0071 - Payment for communication technology-based services for 5 minutes or more of a virtual (nonface-to-face) communication between a rural health clinic (RHC) or federally qualified health center (FQHC) practitioner and RHC or FQHC patient, or 5 minutes or more of remote evaluation of recorded video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit; RHC or FQHC only

Reimbursement amount increased under CARES Act



Virtual Check In

G2012

\$14.80NF
\$13.35 F

- 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; 5-10 minutes of medical discussion

G2010

\$12.27 NF
\$9.38 F

- **Remote evaluation of recorded video and/or images** submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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

Reimbursement Source: National Average, MPFS, 2020



Create Opportunities

Interprofessional Internet Consultation

Not Telehealth

- 99446 – Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 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 – Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time

Requesting physician must document patient consent, including acknowledgement of beneficiary cost-sharing



Qualified NonPhysician Health Care Professional - Online Digital E/M Services

Clinicians who **may not** independently bill for E/M visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

AMA has term E/M but CMS prefers the term “assessment”

- 98970 – Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
- 98971 – 11-20 minutes
- 98972 – 21 or more minutes

- G2061 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
- G2062 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes
- G2063 – Qualified nonphysician health care professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

- Coinsurance and deductible would apply to these services.



Online Digital Documentation

- The interchange between the provider and patient should be stored electronically.
- The provider **MUST** indicate a narrative diagnosis to support billing.
- Time spent be documented in order to support the code billed.



2020 Final PFS: Remote Physiologic Monitoring (RPM)

CMS adopted three codes for chronic care RPM in 2019 (99453, 99454, 99457). The codes involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by a treatment plan. For 2020, CMS finalized the following:

- CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes)
- CPT code 99458 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes). CMS finalized a RVU of 0.61 and finalized the RUC-recommended direct PE.
- Both codes fall under *general supervision*. CMS also states that the supervising provider does not need to be the treating provider, but that only the supervising provider may bill Medicare for incident to services.





Questions to Ask Payers and Things to Consider

WEALTH ADVISORY | OUTSOURCING | AUDIT, TAX, AND CONSULTING

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Questions to Ask Payers

- What are the effective dates? Most insurers are limiting this exemption to a specific period of time.
- What services are covered?
- May these services be provided by Nurse Practitioners, Physician Assistants, and other Qualified Healthcare Providers (QHP)?
- How are those to be billed?
- Do we use telehealth codes or office visit codes?
- What place of service?
- What modifiers are necessary?



But first....

Does the practice's professional liability policy cover telehealth – visits by telephone or audiovisual link?

- Some only cover for established patients
- Some only cover for MDs and not other types of providers
- Some only cover audio-visual links and not telephone calls



EMR Questions

- How to document phone calls and online encounters?
 - Check with EMR vendor – some “encounter types” may not cross over into Practice Management system for billing
 - Place of Service may require manual changes
 - Will encounters be stored where they are easily accessible for clinical purposes or payer review?



Diagnosis Documentation and Coding

- For all visits not related to COVID-19, document and code as normal. Remember the Diagnosis Coding Guidelines, including:
 - Code all documented conditions that coexist at the time of the encounter, and require or affect patient care, treatment, or management.
- For COVID-19 related visits – guidance is available at <http://www.ahima.org/topics/covid-19>
- Effective 4/1/2020 – U07.1 – for confirmed COVID-19.
- For suspected cases, code the symptoms or reason to suspect, such as:
 - Z20.828 – Contact with and (suspected) exposure to other viral communicable diseases
 - R05 – Cough
 - R50.9 – Fever
- Lab results are not required to code as confirmed. Code based on the physician's judgment/documentation.



COVID-19 Diagnosis Code DOS Prior to 4/1/2020

- B97.29 – Other coronavirus as the cause of diseases classified elsewhere

Not specific to COVID-19 – could be used for ANY coronavirus, but for tracking purposes, suggested to only use this for COVID-19

Code first the manifestation/problem – pneumonia, respiratory distress, etc.



340B Implications of Telehealth

- Meet the patient definition
 - Entity has established a relationship with the individual and maintains the individual's health care record
 - Individual seen by an eligible health care provider employed or contracted by Entity
 - Service provided from telehealth within the scope of the grant
- Site eligibility
 - Revenues and expenses generated by telehealth service appear on a reimbursable line of the Medicare Cost Report
- Process is included in policies and procedures
- If further questions – please contact Cheryl Hetland
- cheryl.hetland@CLAconnect.com or 612-376-8423



Resources

- <https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>
- <http://www.ahima.org/topics/covid-19>
- <https://www.deadiversion.usdoj.gov/coronavirus.html>
- <http://statemgma.m3solutionsllc.com/>
- <https://www.aafp.org/patient-care/emergency/2019-coronavirus/telehealth.html>
- <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>
- <https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>





Thank you!

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