COVID-19 CORONAVIRUS

Coding Updates

nthrive

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Telehealth Expansion

UPDATED INFO

See yellow highlights for updated content from previous published version.

Background

Additional temporary emergency rules further expand telehealth services.[1] One of the goals of these actions is to increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home.

Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology-based services (telemedicine) wherever they are located.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. During the public health emergencies, individuals can use interactive apps with audio and video capabilities to visit with their clinician for an even broader range of services. Providers also can evaluate beneficiaries who have audio phones only.

Providers can bill for telehealth visits at the same rate as in-person visits. In addition, providers can waive Medicare copayments for these telehealth services for beneficiaries in original Medicare.

Telehealth visits include emergency department visits, inpatient and observation visits, initial nursing facility and discharge visits, home visits, and therapy services, **which must be provided by a clinician who is allowed to provide telehealth**. New as well as established patients now may stay at home and conduct a telehealth visit with their provider.

While there is abundant information concerning the CMS 1500 and professional fee services, there is minimal information about submitting institutional billing, except when referencing an FQHC or RHC. This is reasonable, considering telehealth services were allowed only within Health Professional Shortage Areas (HPSA) prior to the Public Health Emergency. CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.[2]

As of this date, CMS has not released any additional instructions allowing for hospital-based outpatient telehealth billing.

Telehealth – Professional Billing

To enable services to continue while lowering exposure risk, qualified providers can now deliver the following additional services by telehealth:

- ✓ Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- ✓ Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
- ✓ Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
- ✓ Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- ✓ Critical Care Services (CPT codes 99291-99292)
- ✓ Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327-99328; CPT codes 99334-99337)
- ✓ Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347-99350)
- ✓ Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475-99476)
- ✓ Initial and Continuing Intensive Care Services (CPT code 99477-99478)
- ✓ Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- ✓ Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136-96139)
- ✓ Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- ✓ Radiation Treatment Management Services (CPT codes 77427)
- ✓ Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

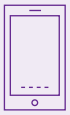
A complete list of all Medicare telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

Eligible providers include Physicians, Nurse practitioners, Physician assistants, Nurse-midwives, Clinical nurse specialists, Certified registered nurse anesthetists, Clinical psychologists (CP), Clinical social workers (CSWs), Registered dietitians or nutrition professionals.

Qualifying services provided at a distant site are billed on a 1500 claim form for professional services:

- ✓ Submit the claim to the contractor for physician/practitioner's service area (where the practitioner providing the service is located).[3]
- ✓ Report the appropriate CPT/HCPCS for Telehealth services.[4]
- ✓ Report the Place of Service for the location where the service would normally have been provided.
- ✓ Apply Modifier 95, *Telemedicine service rendered via real-time interactive audio and video telecommunication.*

Method II Critical Access Hospitals (CAH) where the practitioner has reassigned their benefits to the CAH submit the appropriate HCPCS code for the covered telehealth service with Modifier GT, *Via interactive audio and video telecommunication systems.*[5]

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.	Common telehealth services include: ✓ **99201-99215** (office or other outpatient visits) ✓ **G0425-G0427** (telehealth consultations, emergency department or initial inpatient) ✓ **G0406-G0408** (follow-up inpatient telehealth consultations with beneficiaries in hospitals or SNFs) ✓ Additional E/M level visits for emergency, observation and inpatient: Compliant Medicare Telehealth Services	For new or established patients.
VIRTUAL CHECK-IN 	A brief (5-10 minutes) check in with your provider via telephone or other approved telecommunications device to decide whether an office visit or service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	✓ **G2010** (remote evaluation of recorded video) ✓ **G2012** (brief communication tech-based service) ✓ **G0071** (brief communication tech-based service for RHC ONLY)	For new or established patients.
E-VISITS 	A communication between a patient and their provider through an online patient portal.	**Online digital evaluation:** ✓ **99421** (5-10 minutes) ✓ **99422** (11-20 minutes) ✓ **99423** (21+ minutes) **Online assessment:** ✓ **G2061** (5-10 minutes) ✓ **G2062** (11-20 minutes) ✓ **G2063** (21+ minutes)	For new or established patients including up to 7 days cumulative time.

Under the CARES Act, an RHC and FQHC may act as a distant site provider. (See the RHC/FQHC Payment Update article)

Except for the Evaluation and Management (E/M) codes the services on this table are assigned Status Indicator (SI) M which indicates Items and Services Not Billable to the MAC and not paid under OPPS. These codes are available for professional billing only.

The waivers published to date do not make any change to reporting the originating site fee. The FAQ published on March 17, 2020 includes this response making it clear the patient must be present at an originating site to bill this element of the service.

In addition, throughout the course of the open-door calls with CMS they have stated that if the patient and qualified practitioner are located on the same campus or at facilities with the same provider number that it is not considered telehealth, even if they are using telehealth technology for the visit. Rather the service should be billed just as any face-to-face service would have been.

Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.[6]

To date CMS has not waived this guidance and facilities are prohibited from reporting Q3014 unless the patient is at the facility. It may not be reported when the patient is at home or another location.

Telemedicine Services

Since 2019, Medicare pays for "virtual check-ins" for patients to connect with their doctors without going to the doctor's office. These brief, virtual check-in services are for patients with an established relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service. The Medicare coinsurance and deductible would apply to these services.

Doctors and certain practitioners may bill professionally for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010). These services are not covered under OPPS.

Medicare also pays for patients to communicate with their doctors without going to the doctor's office using online patient

portals. The individual communications, like the virtual check in, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The 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 Medicare coinsurance and deductible would apply to these services.[7]

Medicare also pays for patients to communicate with their doctors without going to the doctor's office using online patient portals. The individual communications, like the virtual check in, must be initiated by the patient; however, practitioners may educate beneficiaries on the availability of this kind of service prior to patient initiation. The 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 Medicare coinsurance and deductible would apply to these services.

CMS has also published a fact sheet addressing telehealth and telemedicine services.[8]

CMS has said that "these services will not be subject to the limitations on Medicare telehealth services in section 1834(m) of the Act because, as we have explained, we do not consider them to be Medicare telehealth services; instead, they will be paid under the PFS like other physicians' services."[9]

Virtual Check-Ins and Telephone Assessments

Although the Interim Final Rule (IFR) indicated a broad range of clinicians in addition to physicians would be able to report these services claim logic, as of this date, has not been updated to allow submission of any claim other than the 1500. Modifier 95 does not apply to these services.[10]

- ✓ Qualified providers can deliver virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- ✓ Qualified providers can also render certain services by telephone to their patients (CPT codes 98966-98968; 99441-99443).

E-Visits

nThrive confirmed through both the April 21 "Office Hours" call with CMS, and a Noridian Part A/B MAC webinar, "Telehealth and Virtual Services – During COVID 19", that hospitals are now able to report these services for all non-physician providers listed in the Interim Final Rule which includes: **licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists**.

Qualified providers will report 99421-99423 and non-physician clinicians will report G2061-G2063. The April 2020 Integrated Outpatient Code Editor (I/OCE) revision published on April 16, 2020 changed the Status Indicator (SI) of these codes to make them payable. 99421-99423 were revised from a SI of M to an SI of B allowing them to be submitted and paid from the physician fee-schedule. G2061-G2063 have been assigned SI "A" **without** Edit 62, *Not recognized by OPPS,* allowing them to be reported on a UB-04.

Remote Patient Monitoring

- ✓ Clinicians can provide remote patient monitoring services to both new and established patients.
- ✓ These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

Removal of Frequency Limitations

The following services are no longer limited on the number of times they can be provided by Medicare telehealth:

- ✓ A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233).
- ✓ A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310).
- ✓ Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (HCPCS codes G0508-G0509).

Other Telehealth and Telemedicine Topics

- ✓ Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.
- ✓ Medicare patients with End Stage Renal Disease (ESRD).
  - Clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site.
  - For Medicare patients with ESRD, CMS will exercise enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.
  - CMS is modifying the requirement which requires the ESRD dialysis facility to ensure that all dialysis patients are seen by a physician, nurse practitioner, clinical nurse specialist, or physician's assistant providing ESRD care at least monthly, and periodically while the hemodialysis patient is receiving in-facility dialysis. CMS is waiving the requirement for a monthly in-person visit if the patient is considered stable and recommend exercising telehealth flexibilities, e.g. phone calls, to ensure patient safety.[11]
- ✓ Home Health Agencies (HHAs) can provide more services to beneficiaries using telehealth within the 30-day episode of care, so long as it's part of the patient's plan of care and does not replace needed in-person visits as ordered on the plan of care. CMS acknowledges that the use of such technology may result in changes to the frequency or types of in-persons visits outlined on existing or new plans of care.

- ✓ Hospice providers can provide services to a Medicare patient receiving routine home care through telehealth, if it is feasible and appropriate to do so. Face-to-face encounters for purposes of patient recertification for the Medicare hospice benefit can now be conducted via telehealth.
- ✓ Nursing Homes:
  - CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.
  - Additional information can be found at: https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf
- ✓ To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.
- ✓ According to a bulletin released by the American Hospital Association (AHA) "this legislation will waive the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as distant sites. Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule."[12]

Guidance

- ✓ Implement strategies to utilize expanded telehealth and telemedicine services to minimize patient and staff exposure.
- ✓ Determine staff eligible to report telemedicine and telehealth services and create charge capture mechanisms for these new services.
- ✓ Ensure documentation supports services rendered and billed.
- ✓ Review guidelines for non-hospital settings and implement telehealth services as appropriate.

Sources

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