Explore Telehealth Service Expansion During the Coronavirus Public Health Emergency

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1:00 p.m. CT

Encore presentation with updates

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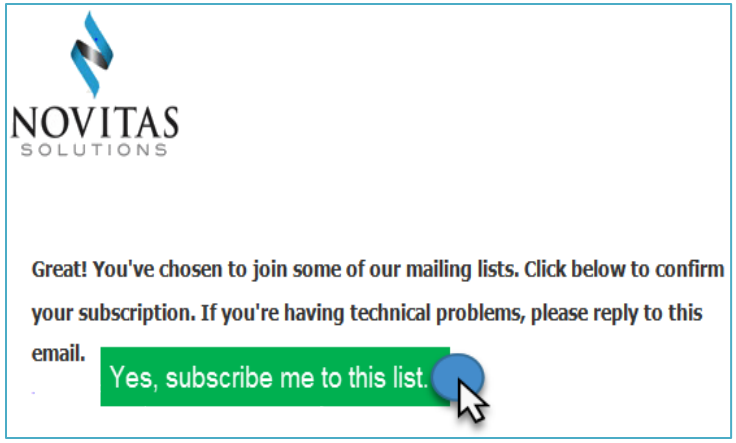

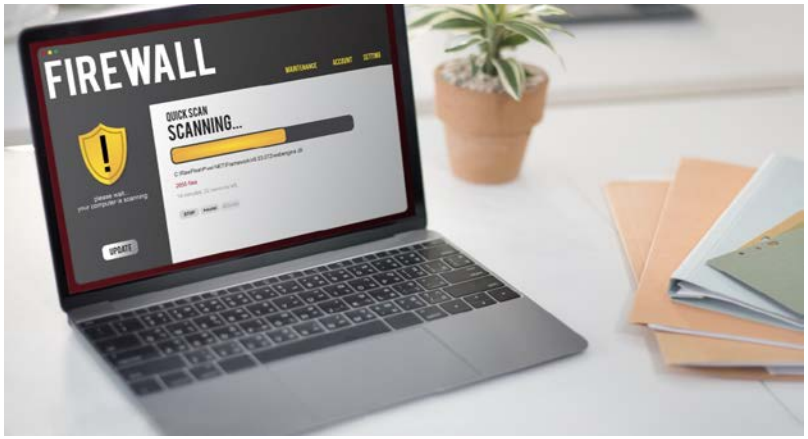

Today's Presentation

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- Agenda:
  - Medicare Telehealth Expansion for COVID-19
  - Telemedicine Services:
    - ✓ Telehealth Visits
    - ✓ Virtual Check-In
    - ✓ E-Visits
    - ✓ Telephone Services
  - Cost Sharing
  - Remote Monitoring and Services
  - Hospital Outpatient Services – Telehealth and Remote Services
- Objectives:
  - Explore the expansion of Medicare telehealth services-under the CMS 1135 waiver
  - Discuss the new waived information relating to the CARES Act
  - Review important resources relating to telemedicine services

Acronym List

Acronym	Definition
CAH	Critical Access Hospital
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CMS	Centers for Medicare and Medicaid Services
CNS	Certified Nurse Specialist
COVID-19	Coronavirus Disease 2019
CP	Clinical Psychologist
CPT	Current Procedural Terminology
CRNA	Certified Registered Nurse Anesthetists
CSW	Clinical Social Worker
CTBS	Communication Technology Based Services
E&M	Evaluation and Management
ESRD	End Stage Renal Disease
FAQ	Frequently Asked Questions
FQHC	Federally Qualified Health Center
HCPCS	Healthcare Common Procedure Coding System

Acronym List Two

Acronym	Definition
HHS	U.S. Department of Health & Human Services
I/OCE	Integrated Outpatient Code Editor
MLN	Medicare Learning Network
NP	Nurse Practitioner
OIG	Office of Inspector General
OT	Occupational Therapist
PA	Physician Assistant
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PT	Physical Therapist
POS	Place of Service
RHC	Rural Health Clinic
RTP	Return to Provider
SLP	Speech Language Pathologist
SNF	Skilled Nursing Facility

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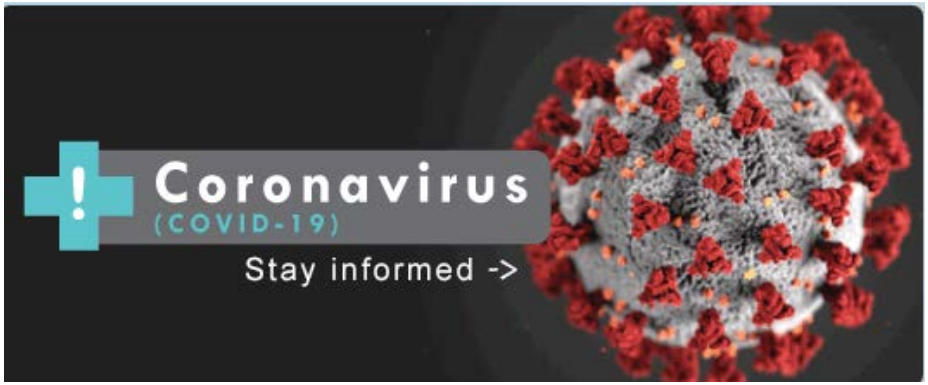

Medicare Telehealth Expansion for COVID-19

Telehealth Expansion – PHE

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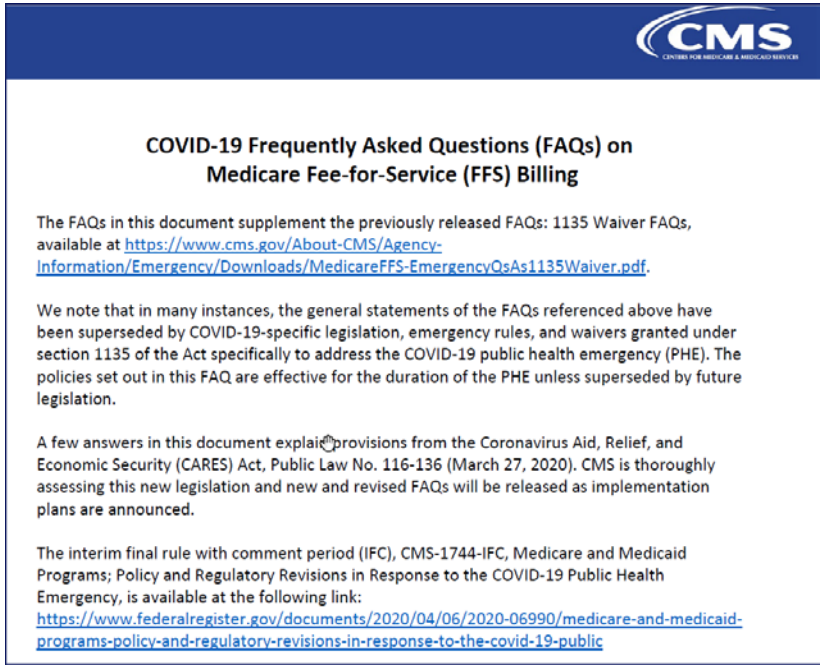
- CMS expanded this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act
- Under the CARES Act:
  - CMS is waiving the requirements of section 1834(m)(1) of the ACT and 42 CFR § 410.78(a)(3) for use of interactive telecommunications systems to furnish telehealth services, to the extent they require use of video technology, for certain services
  - CMS has also expanded coverage for hospitals, RHCs, and FQHCs in regards to telehealth services
- References:
  - COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
  - CMS Medicare Telemedicine Health Care Provider Fact Sheet
  - President Trump expands telehealth benefits for Medicare beneficiaries during COVID-19 outbreak
  - Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic
  - Coronavirus Waivers & Flexibilities:
    - ✓ Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
    - ✓ Hospitals: CMS Flexibilities to Fight COVID-19
    - ✓ Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19
  - Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020

Resources Relating to COVID-19

- Novitas Coronavirus COVID-19 information (JH) (JL):
  - Dedicated page to encourage providers to stay current with all the updates related to COVID-19
- CMS Coronavirus (COVID-19) website:
  - Learn about CMS responses to Coronavirus and find the latest program guidance
- Medicare Coverage and Payment of Virtual Services video:
  - Video released providing answers to common questions about the Medicare telehealth services benefit
- COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing
  - CMS has posted updated frequently asked questions
- SE20011 - Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)
  - Summary of the blanket waivers including telehealth
- Coronavirus Waivers & Flexibilities:
  - Policy changes built on the regulatory waivers and flexibilities
- COVID-19@cms.hhs.gov
  - Questions related to COVID-19 can be directed to CMS

COVID-19 Frequently Asked Questions

- [COVID-19 Medicare Fee-for-Service (FFS) Billing]



CMS

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the previously released FAQs: 1135 Waiver FAQs, available at https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf.

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

A few answers in this document explain provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 (March 27, 2020). CMS is thoroughly assessing this new legislation and new and revised FAQs will be released as implementation plans are announced.

The interim final rule with comment period (IFC), CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available at the following link: https://www.federalregister.gov/documents/2020/04/06/2020-06990/medicare-and-medicaid-programs-policy-and-regulatory-revisions-in-response-to-the-covid-19-public

- Telehealth Information:
  - G. Hospital Outpatient – Locations off of Hospital Campus
  - H. Hospital Outpatient Therapeutic Services Furnished In Temporary Expansion Locations
  - M. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
  - N. Expansion of Virtual Communication Services for FQHCs/RHCs
  - O. Revision of the Home Health Agency Shortage Area Requirement for Visiting Nursing Services Furnished by RHCs and FQHCs
  - P. Medicare Telehealth
  - LL. Hospital Billing for Remote Services
  - MM. Outpatient Therapy Services

Notice of Enforcement Discretion

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- Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for Health Insurance Portability and Accountability Act (HIPAA) violations against health care providers
- Allowing use of communications during the COVID-19 nationwide PHE for video chats such as:
  - FaceTime
  - Skype
  - Google Hangouts
  - Facebook Messenger
- For additional information:
  - Notice of Enforcement Discretion for Telehealth
- CMS encourages all providers to share with patients these new abilities to provide healthcare through telemedicine

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Telemedicine Services

Telemedicine Services Defined

- Telehealth Visits:
  - A visit with a provider that uses telecommunication systems that has audio and video capabilities between a provider and a patient
  - The use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services
- Telephone Services:
  - Non-face-to-face E&M services provided using telephone audio
- Virtual Check-Ins:
  - 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 new or established patient
- E-Visits:
  - A communication between a patient and their provider through an online patient portal

FQHC and RHC Telemedicine Services Update

- RHC and FQHC providers can provide telehealth visits, virtual check-ins and e-visits
- For more information on RHC and FQHC:
  - Watch our calendar of events for an upcoming RHC/FQHC Telehealth webinar (JH) (JL)
  - CMS MLN SE20016 for all Telemedicine updates for all FQHCs and RHCs:
    - ✓ New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE)
- Novitas contacts for FQHCs and RHCs:
  - Kim.Robinson@novitas-solutions.com
  - Gail.Atnip@novitas-solutiosn.com

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Cost Sharing

Cost Sharing Defined

- In general, with telemedicine services the out of pocket costs for beneficiaries has not changed
- Deductible and coinsurance still apply with some exceptions
- HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs
- Reference:
  - Medicare Telehealth Frequently Asked Questions (FAQs)

Modifier CS

- Definition:
  - Cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test
- Purpose:
  - For services furnished on March 18, 2020, and through the end of the PHE, use the CS modifier on applicable claim lines to identify the service as subject to the cost-sharing wavier for COVID-19 testing-related services and to get 100% of the Medicare-approved amount:
    - ✓ Results in the deductible and coinsurance being waived
    - ✓ Services are medical visits for the E&M categories when an outpatient provider, physician, or other providers and suppliers billing Medicare for Part B services orders or administers COVID-19 lab test (examples - U0001, U0002, or 87635)
  - **Note: the CS modifier does not apply to services unrelated to COVID-19**
  - **For telemedicine only report the CS modifier when the service provided is for an evaluation that results with the ordering or administration of COVID 19 testing:**
    - ✓ Adjust previously processed claims if submitted without the CS modifier
- References:
  - COVID-19: Infection Control, Maximizing Workforce, Updated Q&A, CS Modifier for Cost-Sharing, Payment Adjustment Suspended (4/10/2020)
  - COVID-19: Telehealth Video, Coinsurance and Deductible Waived, ASC Attestations, Ambulance Modifiers, Lessons From Front Lines, MLN Call Today 4/7/2020

Applying the CS Modifier

- Apply CS modifier to the following service categories for E&M and the order or administration of COVID-19 testing:
  - Office and other outpatient services
  - Hospital observation services
  - Emergency department services
  - Nursing facility services
  - Domiciliary, rest home, or custodial care services
  - Home services
  - Online digital evaluation and management services
- Cost-sharing (deductible and coinsurance) does not apply to the above medical visit services for which payment is made to:
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System
  - Physicians and other professionals under the Physician Fee Schedule
  - Critical Access Hospitals (CAHs)
  - Rural Health Clinics (RHCs)
  - Federally Qualified Health Centers (FQHCs)
- CS modifier does not apply to MD waiver hospitals and Indian Health Services (IHS) (billed on the UB-04 only)

Cost Sharing Examples

- Patient has a telehealth visit unrelated to COVID-19:
  - Do not report the CS modifier
  - Patient is responsible for applicable coinsurance and deductible
- Patient has telehealth visit related to COVID-19 and the provider orders COVID-19 testing:
  - Report the CS modifier
  - Patient is not responsible for any coinsurance or deductible

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Telemedicine Services: Telehealth

Highlights of Telehealth Services

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- Medicare telehealth services must be furnished using, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner:
  - Includes use of audio-only equipment to furnish services described by the codes for audio only telephone E&M services, behavioral health counseling and educational services:
    - ✓ Includes 99441-99443 (Non-face-to-face physician telephone services)
  - Broader range of telehealth services:
    - ✓ Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020
- Visits are considered the same as in-person visits and are reimbursed according to the PFS
- Examples of Telehealth visits include emergency department visits, initial nursing facility and discharge visits, home visits, and therapy services, which must be provided by a clinician that is allowed to provide telehealth
- References:
  - MLN Connects Special Edition April 30, 2020:
    - ✓ Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

Additional Highlights of Telehealth Services

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- Services can be provided to new or established patients
- Fulfills face-to-face visit requirements for clinicians to see patients, in IRFs, hospice, and home health
- Clinicians can provide remote patient monitoring services to patients with acute and chronic conditions and for patients with only one disease
- Physicians can supervise their clinical staff using virtual technologies when appropriate, instead of requiring in-person presence
- References:
  - MLN Connects Special Edition April 30, 2020:
    - ✓ Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
  - Coronavirus Waivers & Flexibilities:
    - ✓ Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
    - ✓ Hospitals: CMS Flexibilities to Fight COVID-19

Billing for Professional Telehealth Services During PHE

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- CMS allows additional services to be furnished via telehealth
- When billing professional claims for **all telehealth services** with **dates of services on or after March 1, 2020**, and for the duration of the PHE, bill with:
  - POS equal to what it would have been had the service been furnished in-person
  - **Modifier 95** indicating that the service rendered was actually performed via telehealth:
    - ✓ Modifier 95 is defined as synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system
- Reference:
  - MLN Connects Special Edition, Friday, April 3, 2020:
    - ✓ Billing for Professional Telehealth Services During the Public Health Emergency
  - MLN Connects Special Edition, Thursday, April 30, 2020:
    - ✓ Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
  - Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020
  - SE20011 - Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19

Additional Billing for Professional Telehealth Services During PHE

- CR modifier and the DR condition code are not required on telehealth services
- Two scenarios where modifiers are required on telehealth professional claims:
  - Modifier GQ – Used when telehealth services are furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii
  - Modifier G0 – Used for the diagnosis and treatment of an acute stroke
- CAH method II claims bill with the GT modifier
- Reference:
  - MLN Connects Special Edition, Friday, April 3, 2020:
    - ✓ Billing for Professional Telehealth Services During the Public Health Emergency
  - SE20011 - Medicare Fee-for-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19)

Telehealth Services Listing

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- Updates have been made to the list of telehealth services:
  - Temporary codes are listed indicating addition for PHE for COVID pandemic:
    - ✓ New codes were recently added on 4/30/2020
  - Codes were added for audio-only interaction which now meets the telehealth requirement
  - Some examples of Medicare payment limitations include:
    - ✓ 90875 , 96112 , 96170, 96171 – Non covered
    - ✓ S9152 – Not valid for Medicare purposes
    - ✓ G0140 – Statutory excluded
    - ✓ 94005 – Bundled code
- References:
  - Covered Telehealth Services for PHE for the COVID-19 pandemic
  - Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge

Screen Shot of the Excel Table

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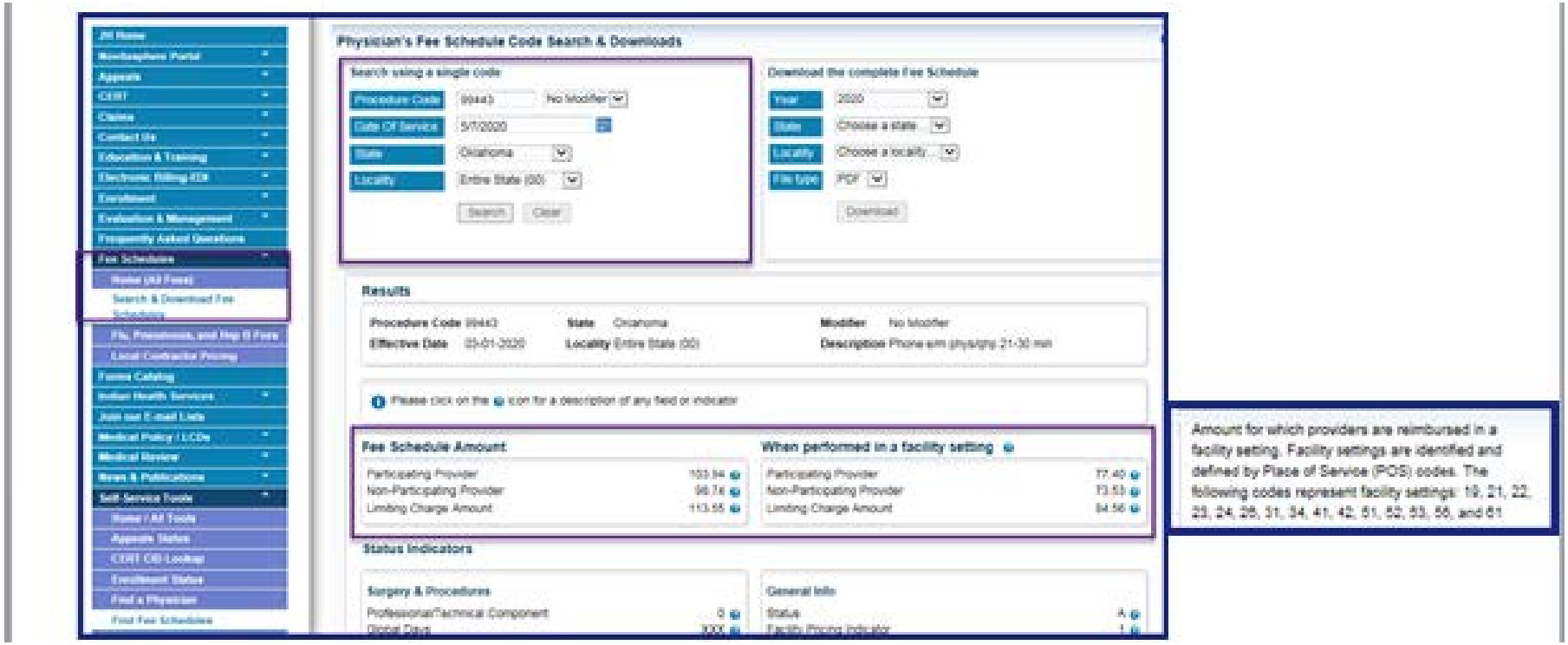
- Covered Telehealth Services for PHE for the COVID-19 pandemic

LIST OF MEDICARE TELEHEALTH SERVICES				
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?	Medicare Payment Limitations
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic		
90785	Psytx complex interactive		Yes	
90791	Psych diagnostic evaluation		Yes	
90792	Psych diag eval w/med srvcs		Yes	
90853	Group psychotherapy	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Non-covered service
90951	Esrd serv 4 visits p mo <2yr			
92507	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
92508	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20	Yes	
92521	Evaluation of speech fluency	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
92522	Evaluate speech production	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
92523	Speech sound lang comprehen	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
92524	Behavral qualit analys voice	Temporary Addition for the PHE for the COVID-19 Pandemic	Yes	
92601	Cochlear implt f/up exam <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92602	Reprogram cochlear implt <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92603	Cochlear implt f/up exam 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
92604	Reprogram cochlear implt 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94002	Vent mgmt inpat init day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94003	Vent mgmt inpat subq day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94004	Vent mgmt nf per day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		
94005	Home vent mgmt supervision	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		Bundled code.
94664	Evaluate pt use of inhaler	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20		

Physician Fee Schedule

- Physician Fee Schedule Look Up (JH) (JL)
- Place of Service Codes (JH) (JL)



Eligible Providers

- The following health professionals can bill for telehealth services:
  - Physicians
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Clinical nurse-midwives (CNM)
  - Clinical nurse specialists (CNS)
  - Certified registered nurse anesthetists (CRNAs)
  - Clinical psychologists (CPs) and Clinical social workers (CSWs)
  - Registered dietitians or nutrition professionals

- Based on the CARES Act and for the duration of the PHE the following providers can perform telehealth:
  - Occupational therapist (OT)
  - Physical therapist (PT)
  - Speech language pathologist (SLP)
- Reference:
  - **Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic**
  - Coronavirus Waivers & Flexibilities:
    - ✓ Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

Distant Site Practitioner Clarification #1

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- Question:
  - Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?
- Answer:
  - No payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home during the PHE
  - Practitioner should report the POS code that would have been reported had the service been furnished in person:
    - ✓ Allow systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person
- Reference:
  - COVID-19 FAQs on Medicare Fee-for- Service (FFS) Billing

Distant Site Practitioner Clarification #2

- Question:
  - Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?
- Answer:
  - Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary:
    - ✓ If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a “distant site”), they should report those services as telehealth services
  - If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks:
    - ✓ The practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

Telehealth Key Takeaways

- Use of audio and video capabilities
- CMS waived the video requirement for certain services:
  - Covered Telehealth Services for PHE for the COVID-19 pandemic, effective March 1, 2020
- Furnished in broader circumstances (office, hospital, and other visits)
- Considered the same as in-person visits and are paid at the same rate as in-person visits
- Furnished to beneficiaries in any healthcare facility and in their home
- Applies to new or established patient

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Telemedicine Services: Telephone Services

Telephone Services

- Virtual patient communication codes will be used to report telephone E&M for beneficiaries who need routine, uncomplicated follow-up for chronic disease or routine primary care:
  - Telephone E&Ms cannot be billed if they originate from a related E&Ms service provided within the previous 7 days or lead to an E&Ms service or procedure within the next 24 hours or soonest available appointment
- Reported for new and established patient for non-face-to-face patient-initiated communications with their doctor using a telephone
- Telephone service codes include:
  - 98966-98968 (Non-face-to-face non-physician telephone services)
  - 99441-99443 (Non-face-to-face physician telephone services):
    - ✓ Medicare payment will be equivalent to the payment for established office/outpatient setting
    - ✓ Clinicians who are furnishing an evaluation and management (E/M) service using audio-only technology can report these codes if required elements of the descriptions are met
    - ✓ Follows the telehealth billing with the modifier 95 and POS equal to what it would have been had the service been furnished in-person
  - Follows telehealth billing which requires the 95 modifier and POS equal to what it would have been had the service been furnished in-person
- References:
  - Coronavirus Waivers & Flexibilities:
    - ✓ Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
  - Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update

Physician Telephone Services

- Physicians can perform certain services by telephone to their patients

HCPCS Codes	Description
99441	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days or leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
99442	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days or leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
99443	Telephone E&M service by a physician or other qualified health care professional who may report E&M services provided to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days or leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

Non- Physician Telephone Services

- Clinicians (physical therapists, occupational therapists, speech language pathologists, and licensed CPs and CSWs) can perform certain service by telephone to their patients:

HCPCS Codes	Description
98966	Telephone assessment and management service provided by a qualified non-physician 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 not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
98967	Telephone assessment and management service provided by a qualified non-physician 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 not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.
98968	Telephone assessment and management service provided by a qualified non-physician 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 not leading to an assessment and management service or procedure with the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents

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- According to August 3, 2020 Medicare News and Updates (JH) (JL) :
  - The current COVID-19 Public Health Emergency (PHE) does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing (CB); however, CMS added CPT codes 99441, 99442, and 99443, to the list of telehealth codes
  - SNFs bill for these physician services separately under Part B when furnished to a SNF's Part A resident
- CPT codes 99441, 99442, and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits will be reprocessed
- If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim

Telephone Services Takeaways

- Non-face-to-face E&M services provided using telephone audio
- Applies to new or established patient
- Cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment
- Payment for 99441-99443 is equivalent to established office/outpatient settings

NOVITAS SOLUTIONS

Telemedicine Services: Virtual Check-Ins

Virtual Check-Ins

NOVITAS SOLUTIONS

- Definition:
  - A brief CTBS (5 – 10 minutes) check-in with the patient's practitioner via telephone or other telecommunications device to decide whether an office or other service is needed
  - A remote evaluation of recorded video and/or images are submitted by patient
- Typically initiated by the patient:
  - Practitioner may need to educate beneficiaries on the availability of the service prior to patient initiation
- Clinicians can provide virtual check in services for new and established patients
- Patient must verbally consent to receive virtual check-in services
- Medicare coinsurance and deductible generally apply to these services

Virtual Check-In Codes

HCPCS Code	Description
G2012	Brief CTBS, e.g. virtual check-in, by a physician or other qualified health care professional who can report E&M 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	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.

Virtual Check-Ins Key Takeaways

- Service is not limited to only rural settings
- Patient must agree to the virtual service
- Applies to new or established patient
- Use HCPCS code G2012 or HCPCS code G2010
- Can be conducted with a broader range of communication methods
- Virtual check in services can be provided for new and established patients

NOVITAS SOLUTIONS

Telemedicine Services: E-Visits

E-Visits

- Definition:
  - E-visits are defined as a communication between a patient and their provider through an online portal
- Not limited to only rural settings:
  - Location includes patient's home
  - No geographic or location restrictions
- Reported for new and established patient for non-face-to-face patient-initiated communications with their doctor using online patient portal
- Medicare coinsurance and deductible generally apply to these service
- E-visits codes include:
  - 99421 – 99423 (online digital E&M services)
  - G2061 – G2063 (qualified non-physician qualified health care)

Physician/NPs E-Visit Codes

- Practitioners (physicians/NPs) who may independently bill Medicare for E&M visits can bill the following codes

CPT Code	Description
99421	Online digital E&M service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
99422	Online digital E&M service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
99423	Online digital E&M service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes

Non-Physician E-Visit Codes

- Clinicians (physical therapists, occupational therapists, speech language pathologists, and licensed CPs and CSWs) who may not independently bill for E&M can perform these e-visits and bill

HCPCS Codes	Description
G2061	Qualified non-physician healthcare 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 non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
G2063	Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes

E-Visit Key Takeaways

- Not limited to only rural settings
- No geographic or location restrictions for these visits
- Initiated by the patient
- Practitioners may educate
- Applies to new or established patient
- Bill using CPT codes 99421-99423 and HCPCS codes G2061-G2063
- Coinsurance and deductible generally apply to these services

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Remote Monitoring and Services

Remote Patient Monitoring

- Clinicians can provide remote patient monitoring services to both new and established patients
- 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(Remote patient monitoring)
    - ✓ 99457-99458 (Chronic care remote patient monitoring)
    - ✓ 99473- 99474 (Blood pressure self-measurement)
    - ✓ 99493-99494 (Psychiatric collaborative care management)
- Remote physiologic monitoring service (99454):
  - Medicare will allow the service to be reported for shorter periods of time than 16 days as long as the other code requirements are met
- Reference:
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

Removal of Frequency Limitations on Medicare Telehealth

NOVITAS SOLUTIONS

- The following services no longer have limitations on the number of times they can be provided by Medicare telehealth:
  - CPT codes 99231-99233:
    - ✓ A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days
  - CPT codes 99307-99310:
    - ✓ 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 G0508-G0509:
    - ✓ Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation
- Reference:
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

Other Medicare Telehealth and Remote Patient Care

NOVITAS SOLUTIONS

- ESRD patients:
  - Clinicians no longer must have one “hands on” visit per month for the current required clinical examination of the vascular access site
  - Exercising 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
- To the extent that a NCD or 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
- 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
- Physician visits:
  - 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
- Reference:
  - Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

NOVITAS SOLUTIONS

Hospital Outpatient Services – Telehealth and Remote Services

Hospital Outpatient Services Accompanying Professional Services Via Telehealth

NOVITAS SOLUTIONS

- During the COVID-19 PHE, the hospital may bill under the PFS for the originating site facility fee associated with the telehealth service if:
  - The beneficiary's home or temporary expansion site is considered to be a **provider-based department of the hospital**; and
  - The beneficiary is registered as an outpatient of the hospital for purposes of receiving telehealth services billed by the physician or practitioner
- References:
  - MLN Connects Special Edition April 30, 2020:
    - ✓ Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
  - Coronavirus Waivers & Flexibilities:
    - ✓ Hospitals: CMS Flexibilities to Fight COVID-19

Originating Site Facility Fee

- Originating Site Facility Fee:
  - Report under HCPCS code Q3014
  - Revenue code 078x
  - No modifier 95
  - CS modifier if applicable
- Billable when the beneficiary receives services via telehealth if:
  - Beneficiary's home or temporary expansion site is considered to be a **provider-based department of the hospital** for the physician/practitioner telehealth service
  - Beneficiary is in a healthcare facility and receives services via telehealth
- Payment amount for HCPCS code is 80 percent of the lesser of the actual charge, or $26.65:
  - Beneficiary is responsible for any unmet deductible amount and Medicare coinsurance

Billing G0463 Versus Q3014

- Hospital bills for the originating site facility fee Q3014:
  - If a distant site practitioner furnishes a telehealth service to a registered hospital outpatient, and hospital staff provide administrative and clinical support
- Hospital bills a hospital outpatient clinic visit G0463:
  - When a professional is located in the hospital and furnishes an E&M outpatient service to a hospital outpatient who is also in the hospital
  - If a physician is practicing from a hospital that has registered the patient as a hospital outpatient in the patient's home, which is serving as a provider-based department of the hospital, CMS considers the physician and patient to be "in the hospital" and usual hospital outpatient billing rules would apply in terms of billing for the service(s) furnished:
    - ✓ In this situation, there is no distant site practitioner and no telehealth service being furnished

Hospital- Only Remote Outpatient Therapy and Education Services

NOVITAS SOLUTIONS

- Hospitals (clinical staff, counselors and other employed staff) may provide the following services either through telecommunications technology or in person, in a temporary expansion location, which may include the beneficiary's home when the **beneficiary is registered as an outpatient of the hospital** and the hospital considers the **beneficiary's home to be a provider-based department of the hospital**:
  - A subset of therapy and educational services are eligible to be provided remotely by the hospital clinical staff
  - Behavioral health and education services furnished by hospital-employed counselors
  - Partial hospitalization program services:
    Individual psychotherapy, patient education, and group psychotherapy
- Hospital may bill for these services as hospital outpatient services, as long as they are:
  - Medically necessary
  - Meet all requirements described by the HCPCS code
  - Service are furnished in a hospital outpatient department of the hospital
- References:
  - MLN Connects Special Edition April 30, 2020:
    - ✓ Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Health Care System Address COVID-19 Patient Surge
  - Coronavirus Waivers & Flexibilities:
    - ✓ Hospitals: CMS Flexibilities to Fight COVID-19
  - Interim Final Rule

Beneficiary's Home as Provider-Based Department

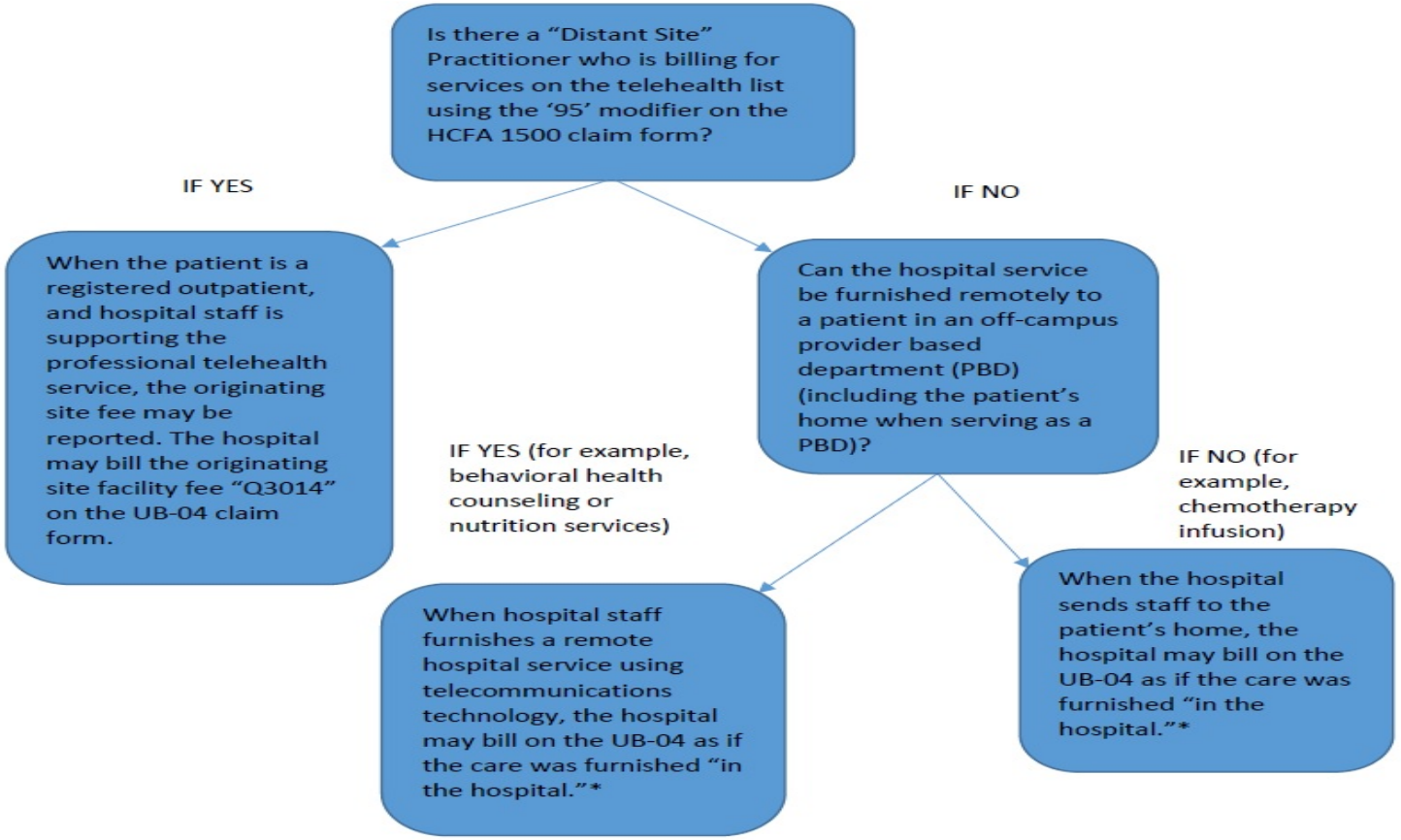
- For purposes of the COVID-19 PHE, on-campus or excepted off-campus PBDs can be considered to have relocated (or partially relocated) to a beneficiary's home, or other temporary expansion location of the hospital, when the beneficiary is registered as an outpatient of the hospital during service delivery:
  - PBD is considered either an on-campus or excepted off-campus PBD
  - Bill with the "PO" modifier for services furnished to beneficiaries in their homes as a relocated (or partially relocated) PBD
  - Receive the full OPPS rate
- If the hospital does not relocate (or partially relocate) an existing on-campus or excepted off-campus PBD to the patient's home and does not seek an exception under the temporary extraordinary circumstances relocation exception policy:
  - Patient's home would be considered a new nonexcepted off-campus PBD
  - Bill with the "PN" modifier for non excepted services
  - Receive the PFS-equivalent rate
- Reference:
  - COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
  - Interim Final Rule

Temporary Expansion of Beneficiary's Home as PBD

NOVITAS SOLUTIONS

- Email the CMS Regional Office
- Request must include:
  - Hospital's CMS Certification Number (CCN);
  - Address of the current PBD
  - Address(es) of the relocated PBD(s):
    - ✓ Beneficiary's home address
  - Date which they began furnishing services at the new PBD(s)
  - Brief justification for the relocation and role of the relocation in the hospital's response to COVID-19
  - Attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan
- Only one relocation request during the COVID-19 PHE is necessary
- Submit within 120 days of beginning to furnish and bill the services

Understanding the Hospital Billing for Remote Services



- * Bill using the PO/PN modifiers as applicable
- * For HOPD services furnished in an off-campus PBD:
  - Bill services as though the care was furnished in the hospital (whether the service is furnished in the patient's home or via real-time audio-visual communications)
  - Properly identify services that can be furnished with telecommunications technology

Hospital Outpatient Services furnished in Temporary Expansion Locations

- **Question**: When hospital clinical staff furnish a service using telecommunication technology to the patient who is a registered outpatient of the hospital and the hospital makes the patient's home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?
- **Answer:**
  - Do not use the modifier 95:
    - ✓ Not a telehealth service
  - Append the DR condition code
  - Use the PO or PN modifier as appropriate
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing:
    - ✓ G. Hospital Outpatient – Locations off of Hospital Campus

MD Waiver Clarifications

- MD waiver hospitals are not paid under OPPS, therefore, they **do not need to report**:
  - The beneficiary's home for the temporary extraordinary circumstances relocation to the CMS regional office
  - The PO or PN modifier
  - The CS modifier because the deductible/coinsurance is not waived for non-OPPS

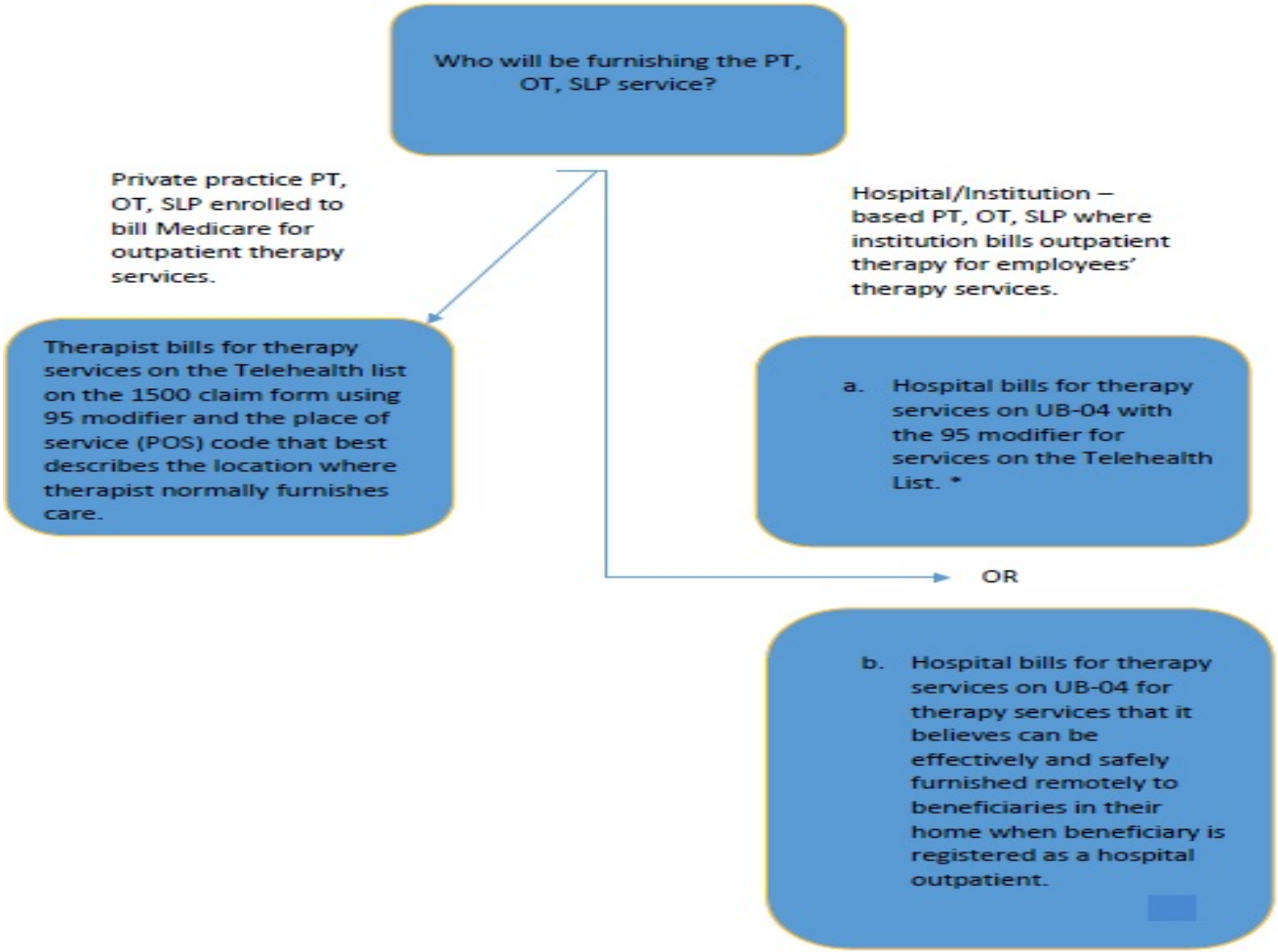
Hospital Billing Recap

- Hospital can furnish services to a beneficiary via telecommunication or in person for a temporary expansion location (including the beneficiary's home) if that beneficiary is registered as an outpatient:
  - Examples of these services include psychoanalysis, psychotherapy, diabetes self-management training, and medical nutrition therapy
- Hospitals can furnish clinical staff services in the patient's home, which is considered provider-based to the hospital during the COVID-19 PHE, and to bill and be paid for these services when the patient is registered as a hospital outpatient:
  - Example: Wound care, chemotherapy administration, and other drug administration
- Clarified that when a patient is receiving a professional service via telehealth in a location that is considered a hospital PBD, and the patient is a registered outpatient of the hospital, the hospital in which the patient is registered may bill the originating site facility fee for the service:
  - Bill HCPCS Q3014
- Reference:
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing:
    - ✓ G. Hospital Outpatient – Locations off of Hospital Campus
    - ✓ H. Hospital Outpatient Therapeutic Services Furnished In Temporary Expansion Locations
    - ✓ LL. Hospital Billing for Remote Services

Outpatient Therapy Services Via Telehealth – Institutional Claim

- **Question**: Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?
- **Answer:** Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the "-95" modifier applied to the service line. This includes:
  - Hospital – 12X or 13X (for hospital outpatient therapy services)
  - SNF – 22X or 23X (SNFs may, in some circumstances, furnish Part B PT/OT/SLP services to their own long-term residents)
  - CAH – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type)
  - Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services
  - Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT & SLP as well as OT services)
  - Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care)
- Reference:
  - COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing Section MM. Outpatient Therapy Services

Outpatient Therapy Options



- *The hospital cannot also bill for the originating site facility fee

Telemedicine Summary of Billable Codes

Telemedicine Service	Description	HCPSs/CPT Codes	Place of Service
Telehealth	A visit with a provider that uses telecommunication systems that has audio and video capabilities between a provider and a patient. • CMS waiver to allow the use of audio-only equipment to furnish E&M services, behavioral health counseling and educational services (99441 -99443) (*)	Review the complete listing of Medicare Telehealth Services Report modifier 95 indicating that the service rendered was actually performed via telehealth	Place of service (POS) equal to what it would have been had the service been furnished in-person.
Telephones	Non-face-to-face E&M services provided using telephone audio	99441 – 99443 (*) follow the telehealth guidance 98966 – 98968	Place of service (POS) equal to what it would have been had the service been furnished in-person.
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.	G2010 and/or G2012	Place of service (POS) equal to what it would have been had the service been furnished in-person
E-Visits	A communication between a patient and their provider through an online patient portal	99421 - 99423 G2061 - G2063	Place of service (POS) equal to what it would have been had the service been furnished in-person

Telemedicine Billing Example Recap – Professional Services

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Type of Service Provided	POS	Modifier(s)
Telehealth visit unrelated to COVID-19	11	95
Telehealth visit related to COVID-19 (test ordered)	11	95 CS
Virtual check-in (no tests ordered)	11	Not applicable
E-visit unrelated to COVID-19	11	Not applicable
E-visit related to COVID-19 (test ordered)	11	CS
Telephone (audio-only) - 99441	11	95
Telephone (audio-only) - 98966	11	Not Applicable

Summary

- Explored the expansion of Medicare telehealth for COVID-19 under the CMS 1135 waiver
- Discussed the new waived information relating to the CARES Act
- Reviewed important resources relating to telemedicine services

Question and Answer Panel is Open

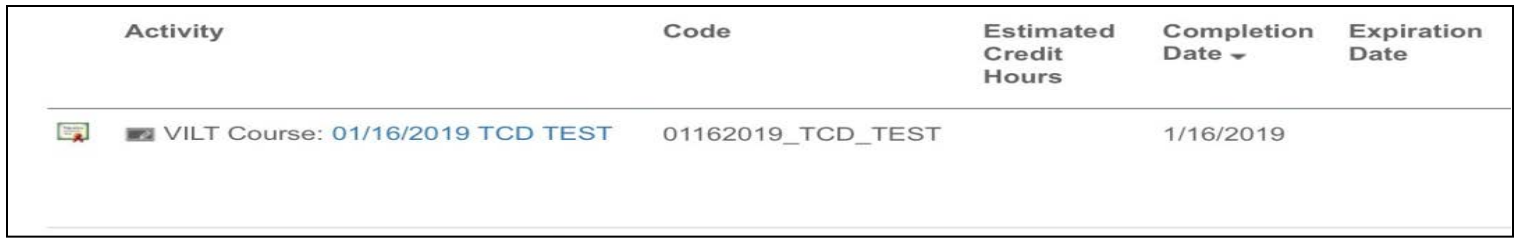
- Responses in the question and answer panel are not considered written guidance of Medicare program requirements. They are intended to complement and not replace Medicare program requirements as set forth in statute, regulations and manual instructions. It is the responsibility of each healthcare professional/supplier submitting claims to Novitas Solutions to familiarize themselves with Medicare coverage requirements.
- Novitas Solutions makes efforts to ensure the information contained in the responses is accurate and current. However, because the Medicare program is constantly changing, it is the responsibility of each provider/supplier to remain abreast of the Medicare program requirements.

Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Jurisdiction L:
  - Customer Contact Center- 1-877-235-8073
  - Provider Teletypewriter- 1-877-235-8051
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)
  - http://www.medicare.gov

Thank You for Attending

- Complete the event satisfaction survey:
  - Pops up immediately after the event ends
- Continuing Education Unit (CEU):
  - Once your attendance for an event is confirmed, you will receive an email notification that you have completed the course:
    - ✓ This process could take up to seven days
  - After you receive your event completed notification email, you can print your CEU Certificate via the Novitas Learning Center:
    - ✓ Click Completed Training icon from Home Page
    - ✓ Certificate icon will be on the left of the Class activity name
    - ✓ Click icon to print your certificate



Activity	Code	Estimated Credit Hours	Completion Date	Expiration Date
VILT Course: 01/16/2019 TCD TEST	01162019_TCD_TEST		1/16/2019	