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Disclosure

As with most topics related to COVID-19, changes are being made rapidly. Please note that this information is current as of the date of this presentation

Your Presenters

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Agenda

- Quick Review – CMS Waiver Revisions & Updates
- Audiovisual Telehealth
- Phone-Only/Audio-Only "Telehealth"
- Reimbursement Changes
- Cost Report Impact & Considerations
- Q&A

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CMS Actions – COVID-19

- Under H.R. 6074, the 1135 waiver authority, CV Bill #3, CARES Act & Interim Final Rule, Congress & CMS issued initial waivers specific to telehealth & virtual communication services that loosened restrictions & expanded access to health care for services rendered during the PHE
- CMS, MLN Matters SE20016 was released April 17, 2020, & provided additional guidance for rural health clinics (RHCs) & federally qualified health centers (FQHCs)
- **CMS released an updated MLN Matters article SE20016 & second Interim Final Rule on April 30, 2020**

Source: https://www.cms.gov/files/document/se20016.pdf

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CMS Part B Waiver Revisions – 4/30/20

› **Expanded list of eligible practitioners**
- CMS has waived limitations on types of clinical practitioners who are eligible to render telehealth services as long as the practitioner is working under their state scope of practice
- "Now, other practitioners are able to provide telehealth services, including physical therapists, occupational therapists and speech language pathologists" – effective March 1, 2020
- **NOTE:** If a PT, OT or ST service is rendered over audiovisual technology, the CPT or HCPCS code rendered is billed
- **NOTE:** If a PT, OT or ST service is rendered over phone-only/audio-only, then the primary Medicare codes G2012 or G2010 would be appropriate

Source: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid;

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

CMS Waiver Revisions – 4/30/20

› **Billing the facility component for distant site telehealth services rendered in provider-based departments – patient at home**
- "Hospitals may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home"
- Medicare will reimburse the "statutory payment that is made to the facility for providing the site where the patient is located, and any other administrative or clinical support, for a telehealth service"
- Until the end of the PHE, "when a patient is receiving a professional service via telehealth in a temporary expansion location that is a PBD of the hospital, 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"
- It is inferred the hospital would bill the Q3014 & be paid under the fee schedule rate of $26.25

Source: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

Telehealth & Virtual Communication

There Are Still Three Categories

Category	Description
Audiovisual Telemedicine	• A substitute for an in-person E/M or other visit • Synchronous two-way, real-time interactive audiovisual communication or asynchronous store & forward communication • **NEW** – Audio-only E/M or other services will be allowed!
E-Checks	• Brief five to 10 minute phone call, initiated by patient, "triage" to determine next steps • Should not be related to an E/M service rendered in the prior seven days or result in a scheduled face-to-face appointment within the next 24 hours
Digital or Portal E-Visit	• At least five minutes of time spent over a seven-day time period

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CMS Updated List of Telehealth Services

- CMS will maintain & continue to update the list of eligible telehealth professional services on a sub-regulatory basis, "considering requests by practitioners now learning to use telehealth as broadly as possible"
- The list has been revised with columns to show what codes have been temporarily added for use during the PHE, *& to what services are eligible to bill to Part B under the CPT or HCPCS service code if rendered during an audio-only/phone-only remote service, i.e.*, behavioral health services
- **Note:** For Part B billing, an audio-only/phone-only E/M service should continue to be billed under 99441-99443 & not with the E/M service codes

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

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Definition – Originating Site

- Where an eligible Medicare beneficiary is located when the telehealth service is rendered
- The "facility" component of the communication

› Revisions under Waiver 1135, CARES Act & Interim Final Rule released March 17, 2020
  - No restrictions on originating site or location
  - Patient may be located anywhere, not just in a MSA, HPSA or nonurban location
  - Patient may still present to an eligible health care site
  - Patient home was added as an eligible originating site
  - Changes to the definition of originating site effective March 6, 2020

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Billing for Originating Site – Patient in a Health Care Entity

› **Q3014** – Billed by the health care site where the patient is physically located

› **Clinic** – CMS-1500, POS code for the site where the patient is, *i.e.*, 11-office, 22-on campus PB clinic, 19-off-campus PB clinic

› **RHC or FQHC** – UB-04, 711 (RHC) or 771 (FQHC) TOB, revenue code 0780

› **Hospital** – UB-04 TOB 12X, type of service "9-other items & services", revenue code for the site of service, *i.e.,* 510 clinic
  - **If CAH, modifier GT is appended**

› Paid under Medicare Physician Fee Schedule allowance
  - **CY 2020 – $26.65**

Billing for Originating Site – Patient Is at Home

- Based on CMS guidance issued April 30, 2020
- "*Hospitals* may bill as the originating site for telehealth services furnished by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is located at home"
- No separate billing of Q3014 has been approved for RHC or FQHC (*not defined as hospital outpatient departments*)

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Definitions – Distant Site Practitioner

- An eligible provider who can furnish & be paid for covered telehealth services rendered through audio & video telecommunication system

- 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 Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.
- Registered dietitians or nutrition professional

Effective March 27, 2020, the CARES Act removed restrictions in place prior to the COVID-19 emergency, allowing RHCs & FQHCs to serve as distant site providers *through the end of the PHE*

Per guidance issued April 30, 2020, CMS added PT, OT & ST professionals to list of eligible distant site providers for audiovisual telemedicine services

CMS has also expanded telehealth to include phone- or audio-only E/M telehealth services if the patient has no access to audiovisual technology

Audiovisual Telehealth Distant Site Services
- Part B -

- Billed on a CMS-1500 claim form
- Must be an eligible professional service on the CMS telehealth code list & rendered through audiovisual
- Assign CPT or HCPCS code describing the service rendered, *i.e.*, office visit 99213
- Assign place of service (POS) code that reflects the site "where the service would have been furnished in person," *i.e.*, 11-office, 22-outpatient hospital clinic
- Append Modifier -95 to CPT or HCPCS code. Identifies service as telehealth
- Service is paid under the applicable facility or nonfacility fee schedule allowance

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Phone-Only Telehealth Distant Site Services
- Part B -

- Billed on a CMS-1500 claim form
- Assign CPT 99441 (5-10"), 99442 (11-20") or 99443 (21"+) based on time threshold met
- Assign place of service (POS) code that reflects the site "where the service would have been furnished in person," *i.e.*, 11-office, 22-outpatient hospital clinic
- Service is paid under the applicable facility or nonfacility fee schedule allowance

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Audiovisual Telehealth Distant Site Services - RHC - *Effective DOS January 27, 2020 Through June 30, 2020

- Bill on the RHC UB-04 claim form HHS
- Must be an eligible professional service on the CMS telehealth code list
- Assign HCPCS code **G2025**
- **Append Modifier CG (required) Modifier 95 (optional)**
- Service will initially be paid under the current all-inclusive rate (AIR), but reprocessed on July 1, 2020, at the established fee schedule amount of **$92.03**

Source: https://www.cms.gov/files/document/se20016.pdf

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Audiovisual Telehealth Distant Site - RHC - *Effective DOS July 1, 2020 Through the End of the PHE

- Bill on the RHC UB-04 claim form
- Must be an eligible professional service on the CMS telehealth code list
- Assign HCPCS code **G2025**
- **No CG modifier**
- **Modifier 95 is optional**
- Service will be paid under established rate of **$92.03**

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RHC Claims for Telehealth Services from January 27, 2020 through June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	CG (required) 95 (optional)

RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

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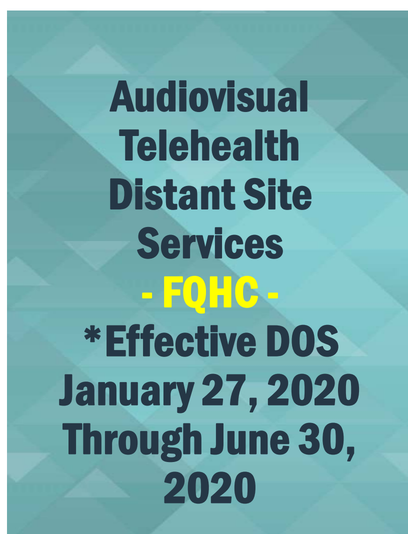

- Bill on the FQHC UB-04 claim form
- Must be an eligible professional service on the CMS telehealth code list
- Assign FQHC Specific Payment Code (G0467)
- Assign service code, *i.e.*, 99214
- Assign HCPCS code **G2025**
- Append Modifier 95 to service code & G2025 (optional)
- Service will initially be paid under the current PPS visit rate, but reprocessed on July 1, 2020, at the established fee schedule amount of **$92.03**

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Audiovisual Telehealth Distant Site - FQHC - *Effective DOS July 1, 2020 Through the End of the PHE

- Bill on the FQHC UB-04 claim form
- Must be an eligible professional service on the CMS telehealth code list
- Assign HCPCS code **G2025**
- **No FQHC specific payment code or service code**
- **Modifier 95 is optional**
- Service will be paid under established rate of **$92.03**

Example of FQHC Claims for Telehealth Services January 27, 2020 through June 30, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G0467 (or other appropriate FQHC Specific Payment Code	N/A
052X	99214 (or other FQHC PPS Qualifying Payment Code)	95
052X	G2025	95

FQHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
052X	G2025	95 (optional)

Visual Aids
- FQHC Claim Detail -

Phone-Only/Audio-Only Telehealth Services – RHC & FQHC

- Effective March 1, 2020, CMS will allow RHCs or FQHCs to **bill phone-only/audio-only services under G2025**
  - Reimbursement calculated to include average of Part B fee schedule allowance for 99441-99443
- "At least five minutes of 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"**
  - **CMS IFC clarified that new or established visits may be phone or audiovisual**
- May not be billed if "originating from a related E/M service provided within the previous seven days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment"
- Reimbursement will be at the fee schedule allowance of **$92.03**

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Source: https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf

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Virtual Check-In – Part B

G2010 – Review of images or documentation sent from patient
G2012 – E-check

Virtual communication, *e.g.*, phone call, initiated by the patient. Could be an initial call & return call by provider after "appointment' is scheduled

At least five minutes of technology-based or remote audio evaluation services

Can be for new or established patients (effective during COVID-19 emergency)

Cannot be related to a visit provided related within the prior seven days & does not result in a visit within the next 24 hours or soonest available appointment

If either of the caveats are met, the virtual check-in is not billed separately from the prior or subsequent in-person visit charges

Source: CMS, Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2018 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

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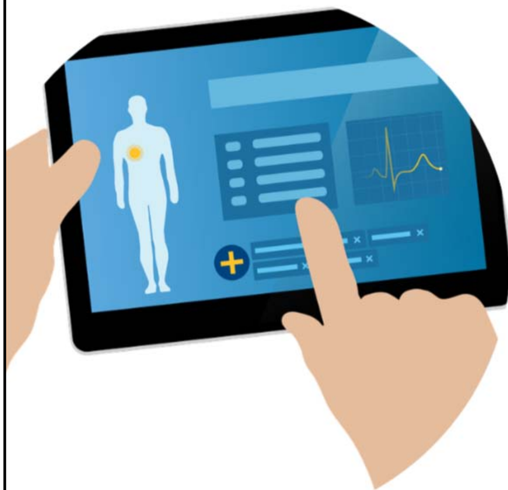

Digital E-Visits – Part B

- Online digital E/M service, *e.g.*, portal
- **CPT Digital visit codes 99421 (5-10"), 99422 (11-20") & 99423 (21"+)**
- The provider spends at least five or more minutes **over the course of seven days** providing online E/M services
  - Seven days must lapse before you bill again for the same condition
    - Includes multiple digital visits over the course of seven days if for related signs/symptoms/conditions
- For new & established patients during emergency period

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Virtual Check-In – RHC & FQHC

G0071 – Established specifically for RHC & FQHC reporting effective January 1, 2019, instead of using G2012 & G2010 (Part B providers)

For the emergency period effective March 1, 2020, CMS will pay the average of the fee schedule allowance for G2010, G2012, 99421, 99422 & 99423, or $24.76

Virtual communication, *e.g.*, phone call, initiated by the patient. Could be an initial call & return call by provider after "appointment' is scheduled

At least five minutes of technology-based or remote audio evaluation services

Can be for new or established patients (effective during COVID-19 emergency)

Cannot be related to a visit provided related within the prior seven days & does not result in a visit within the next 24 hours or soonest available appointment

If either of the caveats are met, the virtual check-in is not billed separately from the prior or subsequent in-person visit charges

Source: CMS, Virtual Communication Services in Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) Frequently Asked Questions December 2018 (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf

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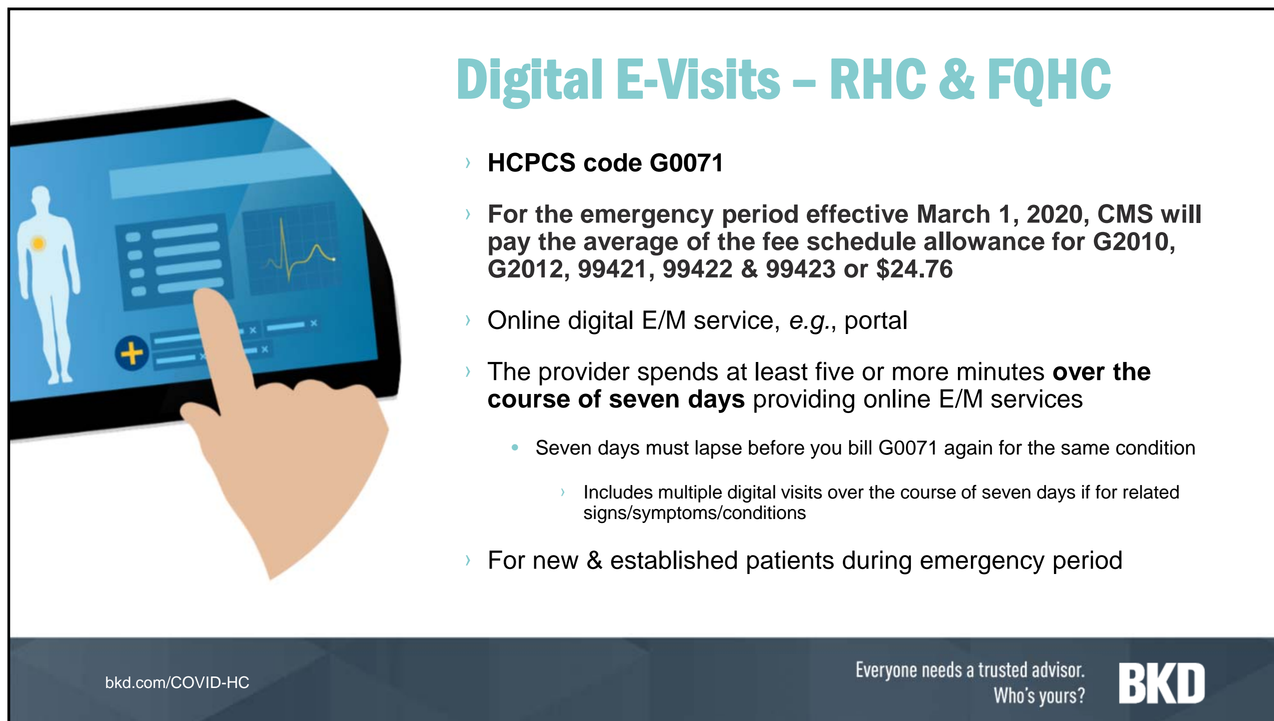

Consents – G0071

- A patient consent is required for both the e-check & a digital visit
- The CMS Interim Final Rule states consent can be obtained when the service is furnished instead of prior to the service being furnished during the emergency period, but must be obtained prior to billing
- Consent (verbal or written) may be obtained by ancillary staff under the general supervision of the RHC or FQHC provider

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Source: CMS Interim Final Rule, Section L(1)(b)

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Waiving Cost Sharing

- A RHC or FQHC may waive cost sharing for telehealth services by appending **modifier CS** to the billed service code(s)
- Effective for services furnished on "March 18, 2020 through the duration of the COVID-19 PHE, CMS will pay all the reasonable costs for the specified categories of E/M services if they result in an order for or administration of a COVID-19 test and relate to the furnishing or administration of such test or to the evaluation of an individual for purposes of determining the need for such test, including applicable telehealth services"
- Medicare will initially pay with the coinsurance applied & then the MAC will automatically reprocess claims beginning July 1, 2020, for the full allowance

*MLN Matters SE20011 & SE20016

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Cost Report Impact

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Medicare Cost Report Impact

- Direct costs of providing telehealth services should be captured in a nonreimbursable cost center as telehealth visits are not considered face-to-face visits subject to Medicare PPS
- A reasonable allocation of time should be made between providers, nurses, etc. (personnel that are providing care) between telehealth & face-to-face encounters so an allocation of cost can be reasonably made
- Visit records must segregate face-to-face versus telehealth visits

Medicaid Cost Report Impact

- Direct costs of providing telehealth services should be treated the same as face-to-face visits if your state Medicaid program has indicated that your Medicaid PPS rate will be used to provider payment. If not, then the cost should be captured in a nonreimbursable cost center (similar to Medicare)
- No allocation of time would be necessary if the visit is treated as a PPS visit – if not, then allocate time similar to Medicare

Visit Recaps

Vital to Keep

Medicare Cost Report Implications

- Medicare RHC All-Inclusive Rate (AIR)
  - Face-to-face visit with a physician, physician assistant, nurse practitioner, nurse midwife, visiting nurse, clinical psychologist or clinical social worker
- Medicare RHC AIR excludes
  - Chronic care management
  - Telehealth services

Medicare Cost Report Implications

- Free-standing RHCs & RHCs provider based to a hospital with greater than 50 beds
  - AIR – $86.31 per visit for CY 2020
- RHCs provider based to a hospital with less than 50 beds, including critical access hospitals (CAH)
  - AIR – cost per visit
    - Subject to productivity standards

Medicare Cost Report Implications

- RHCs provider based to a hospital with less than 50 beds, including critical access hospitals (CAH)
  - Due to COVID-19, some hospitals have had to increase their bed capacity to address increased need for inpatient care
  - To prevent RHCs that are currently exempt from the national per-visit from losing their exemption due to the COVID-19 Public Health Emergency (PHE), CMS will use the number of beds from the cost reporting period prior to the start of the COVID-19 PHE for determining exemption to the payment limit

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Medicare Cost Report Implications

- RHCs provider based to a hospital with less than 50 beds, including CAHs, must
  - Identify & track telehealth cost
  - Maintain time studies to determine physicians, physician assistants & nurse practitioners telehealth service hours & cost
    - Exclude telehealth service from RHC practitioner productive time
  - Report telehealth service in separate RHC nonallowable cost center
  - Exclude telehealth “visits” from RHC total “face-to-face encounter” visits

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Medicare Cost Report Implications

- RHCs provider based to a hospital with less than 50 beds, including CAHs
  - Identify & track telehealth cost
  - Maintain time studies to determine physicians, physician assistants, & nurse practitioners telehealth service hours & cost
    - Exclude telehealth service from RHC practitioner productive time
  - Report telehealth service in separate RHC nonallowable cost center
  - Exclude telehealth “visits” from RHC total “face-to-face encounter” visits

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Medicare Cost Report Implications

- RHCs provider based to a hospital with less than 50 beds, including CAHs
  - Evaluate telehealth impact on RHC cost per visit
    - Telehealth costs will receive an allocation of the hospital overhead costs
  - Evaluate telehealth impact on RHC practitioner productivity limits
  - Evaluate telehealth impact on Medicare utilization on “face-to-face” encounter visits
  - Evaluate telehealth reimbursement impact

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Medicare Cost Report Implications

- For services furnished on March 18, 2020, through the duration of the COVID-19 PHE, CMS will reimburse the reasonable costs for specific E/M services if they result in
  - An order for or administration of such test & relate to the furnishing or administration of such test
  - Or to the evaluation of an individual for purposes of determining the need for such test
  - RHCs will need to determine
    - Staff costs (includes telehealth)
    - Staff time
    - Medical supply cost
    - COVID-19 test cost

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Questions?

Additional Resources

- CMS COVID-19 Website – https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- CMS Waivers & Flexibilities – https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- CMS MLN Fact Sheet – Rural Health Clinic, ICN MLN006398 May 2019
- CMS Telehealth Website – https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/
- CMS Fact Sheet – https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- Novitas Solutions, “Telehealth Services”
- Refer to State Medicaid billing & reimbursement coverage (provider bulletins, manuals, policies, state statutes) – specific to each payor
- Refer to Commercial or MCO plan billing & reimbursement coverage (provider bulletins, manuals, policies) – specific to each payor

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