# Nothing is Certain But Change... Dealing with the Changing Compliance and Reimbursement Requirements in Telehealth

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## Today's Topics:

- Now what? The current landscape of telehealth changes to coding and reimbursement
- But do we really need to document so much? Complying with telehealth documentation requirements
- What about methodologies? Can I use my FaceTime now? Updates to complying with communications



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# What Is Telehealth?

Per the Centers for Connected Health, Telehealth is a collection of means or methods for enhancing health care, public health and health education delivery and support using telecommunications technologies. Telehealth encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services. Telehealth is not a specific service, but a collection of means to enhance care and education delivery.

The Centers for Medicare and Medicaid Services defines Telehealth as Telehealth, is the use of telecommunications technology to provide health care services to persons who are at some distance from the provider. It involves a spectrum of technologies. Coverage and payment for Medicare telehealth includes consultation, office visits, individual psychotherapy, pharmacologic management and other services delivered via an interactive audio and video telecommunication.

Thanks to the Public Health Emergency, or PHE, these definitions may likely see a change coming in the near future!

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# Remember The Old Days?

- Strict requirements for patient and provider location.
- No telephone/audio only visits permitted under Medicare and most Medicaid plans as telehealth.
- Limited list of eligible providers.
- Limited list of covered procedure codes.
- Co-payments must be collected for all services.
- Place of Service must be 02.
- Limited modifiers for special exceptions.
- Existing relationship with the provider.

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## The Changing Landscape of Telehealth

### DURING THE PHE

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# The Changing Landscape of Telehealth During the PHE

New providers added to the list of eligible providers.

Over 100 codes added to the covered services list.

Modalities have increased from video only equipment.

Increased parity rates for phone visits and telehealth visits.

New modifiers and adjusted reimbursement opportunities.

Removal of existing relationship requirements.

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# Diving Deeper into Change

- Gone are the days where audio only was not permitted for Telehealth. At least for now!
- Acceptable modalities for telehealth have increased to include telephone, Face Time, Skype, and other smart phone capabilities that were previously prohibited.
- Another significant change is the allowance of the patient's home as an acceptable originating site for telehealth during the PHE.
- Provider geographical requirements are no longer a barrier to providing telehealth services under the PHE, though newly eligible locations of service may not be eligible for the facility fee.

Centers for Medicare and Medicaid Services. Telehealth Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

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# More Provider Options

The list of telehealth eligible providers was expanded to include:

- Licensed Clinical Social Workers
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Providers who can not bill independently may bill incident to.

Centers for Medicare and Medicaid Services. Telehealth Fact Sheet. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

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# More Services and Options

- There are over 140 codes now added to the CMS Telehealth Services list. Many of these are now indicated for audio only.
- Notable changes include the addition of therapy evaluations, group therapy sessions, emergency visits, home visits, and phone evaluation visits.
- Wellness visits and annual visits are permitted via telehealth, with patient-reported vitals being accepted.
- Telephone visits are now reimbursable through CMS. Additionally, the codes are reimbursed at the same rate as face-to-face visits.
- Direct Supervision may be provided through audio and video capabilities (No audio only). This allows for Incident To services through Telehealth.

Centers for Medicare and Medicaid Services (2021). COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

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## More Options for Alternative Settings

- Hospitals may bill for services furnished remotely by hospital-based practitioners to Medicare patients registered as hospital outpatients, including when the patient is at home when the home is serving as a temporary provider-based department of the hospital.
- Hospitals may bill as originating site for hospital physicians when the patient is an outpatient at home.
- More options for Skilled Nursing Facilities to utilize Telehealth.
- Opportunities for Home Health and Hospice to utilize Telehealth during the PHE.
- Flexibilities with licensure requirements across state lines.

Centers for Medicare and Medicaid Services. Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19. https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf



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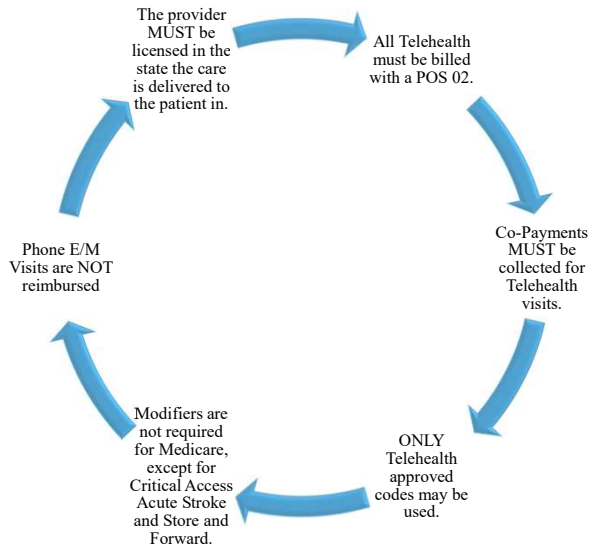
## Billing BEFORE the PHE….



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# Billing AFTER the PHE…

| | |
|---|---|
| ~~All Telehealth MUST be billed with POS 02.~~ | • Place of Service 02 IS still permitted; however, to maximize reimbursement with CMS, it is advisable to bill the POS where the patient is typically seen face to face, with a modifier of 95. Medicaid plans may still use POS 02.<br>• Billing POS 02 DOES result in a lower facility rate reimbursement, while POS of intended visit and modifier 95 results in normal face to face reimbursement rates. |
| ~~The provider MUST be licensed in the state the care is delivered to the patient in.~~ | • Under the PHE, flexibilities are being granted to providers who are across state lines and providers not licensed in the state the patient is located in.<br>• Reviewing state and payor criteria is critical to ensure appropriate provider billing. |
| ~~Co-Payments MUST be collected for all Telehealth patients.~~ | • The OIG has confirmed the allowance for waiver of co-pays and co-insurance under the PHE without risk of scrutiny. |

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OIG (2020). OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf

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# Billing AFTER the PHE…

| | |
|---|---|
| ~~ONLY Telehealth approved codes may be used.~~ | • Some payors are permitting the use of Telehealth with codes previously not on the list and have added audio only options.<br>• Some payors are requiring the face-to-face codes be used for ALL telehealth, regardless of modality. |
| ~~Modifiers are not required for Medicare, except for Critical Access Hospitals, Acute Stroke and Store and Forward.~~ | • As noted above, modifier 95 is back in play for Medicare. For Medicaid plans, modifier GT may be used, depending on the state.<br>• Modifier CS has been added for the waiver of co-payments to allow reimbursement at 100% when patients are unable to pay the copayments. |
| ~~Medicare and Medicaid billing is very straightforward and consistent.~~ | • Many states have variation between the coding and billing changes that have been implemented under the PHE. Some align with Medicare, and some do not.<br>• Reviewing the state and payor criteria for billing is more important than ever! |

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Centers for Medicare and Medicaid Services (2021). COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

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# Not All Changes are Temporary…

BEYOND THE PHE

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## Category I Additions (Beyond the PHE)

- Psych Group therapy (CPT code 90853)
- Psychological and Neuro-psychological Testing (CPT code 96121)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

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Center for Connected Health Policy. https://www.cchpca.org/about/about-telehealth

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# Category 3 Additions (Through Calendar Year End of the PHE)

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facilities discharge day management (CPT 99315-99316)
- Psychological and Neuropsychological Testing ( CPT 96130- 96133; CPT 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- Hospital discharge day management (CPT 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT 99478- 99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)

Center for Connected Health Policy. https://www.cchpca.org/about/about-telehealth

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# Other Permanent Changes

- Nursing Care Frequency Limitations changed to once per 14 days for follow up nursing facility care.
- Addition of Code G2252,which allows an audio only visit of 11-20 minutes to be billed when determining the need for an in-person visit. This is considered "Communication Technology-Based Services" to avoid future restrictions in location. This is considered to be the answer to past concerns that G2012 does not provide sufficient time to make this determination.
- Addition of codes G2250 and G2251 for non-physician providers, such as social workers, physical and occupational therapists and psychologists to utilize for virtual check ins. G2012 will no longer be accepted for these providers in 2021.

Center for Connected Health Policy. https://www.cchpca.org/about/about-telehealth

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## But do we really need to document so much? Complying with telehealth documentation requirements

 

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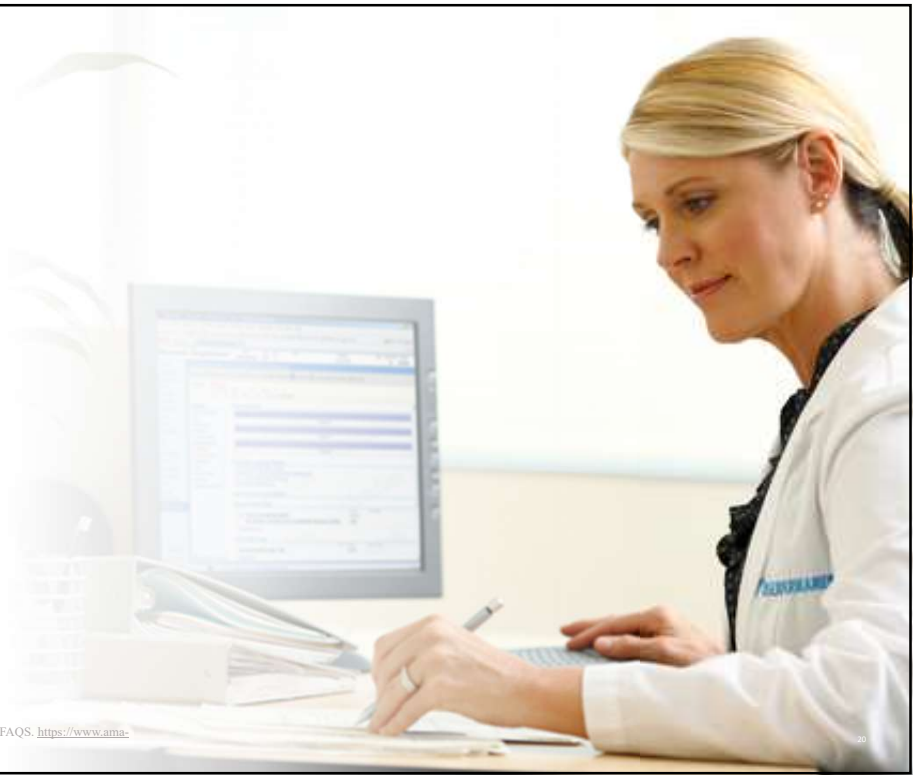
## Documentation Requirements

While CMS is vague about documentation requirements for Telehealth visits, the recommendation from the American Medical Association is to capture the following:

- Method of communication.
- Location of the provider and the patient at the time of the visit.
- During the PHE, document that the visit occurred during the PHE.
- Document as you would an in-person visit to the extent possible.
- Document the amount of time spent with the patient.
- Any vitals that the patient can report.
- Any additional information that may be required as a condition of the CPT code being reported.



American Medical Association (2020). Telehealth During the COVID-19 PHE and FAQS. https://www.ama-assn.org/system/files/2020-05/telemedicine-during-phe-faqs.pdf

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# Additional Documentation Updates

- CMS has provided flexibility for obtaining consent verbally or at the time of treatment, and allowance for obtaining annually for virtual and CBTS visits.
- The patient's consent is not required to be noted in the medical record for telehealth services furnished using interactive audio-video technology.
- The audio only visits also do not require the patient's consent to be noted in the medical record.
- Visit documentation requirements may vary greatly depending on the payor and the state.
- CMS has indicated there will be no audits to determine if a previous relationship existed prior to telehealth visits during the PHE.
- If services are performed that are not clearly defined under the PHE, documentation to support those decisions will become key as the OIG evaluates new audits under Telehealth.

American Medical Association (2020). Telehealth During the COVID-19 PHE and FAQS. https://www.ama-assn.org/system/files/2020-05/telemedicine-during-phe-faqs.pdf

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# Documentation Requirements – Payor Dependencies

- There are payors that are requiring that documentation clearly state the intent for the telehealth visit to replace a face-to-face visit, due to the PHE. Also, the reason for the replacement of face to face being due to the PHE.
- Some payors are also requiring that the documentation be just as thorough as a face-to-face visit, capturing the same elements that would be captured in a traditional in person visit.
- For audio visits that do NOT meet the full criteria of the face-to-face E/M code, some payors may require that G2012 be billed instead.

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## What about methodologies? Can I use FaceTime now? Updates to complying with communication requirements.



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## Changes to Technology

- The HHS Office for Civil Rights (OCR) issue guidance that allowed providers to use platforms to provide telehealth that may not fully conform to HIPAA rules, so long as the patient care is provided in good faith.

- Examples of acceptable platforms for audio and video include:

  - ✓ FaceTime
  - ✓ Facebook Messenger
  - ✓ Google Hangouts
  - ✓ Skype
  - ✓ Zoom

Health and Human Services (2020). FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency. https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf



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# Not All Platforms Are a Go

The OCR has maintained that some platforms are not acceptable for Telehealth. This includes any platform that may be public facing.

Examples of unacceptable platforms include:

- Facebook Live
- Twitch
- Tik Tok
- Reels


Health and Human Services (2020). FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency. https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

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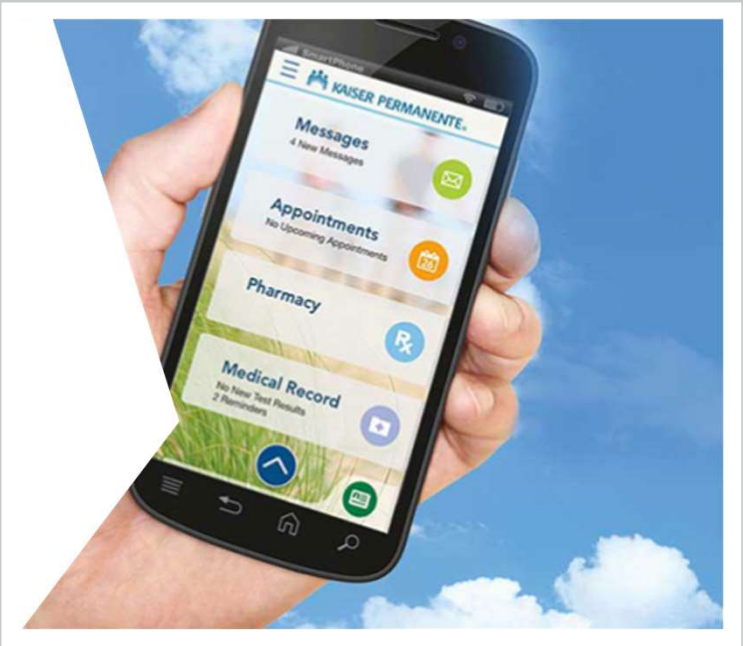


# For those days when video chat is not an option…

• There are a few other ways the provider and patient can communicate.

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# Audio Only Modalities

- Audio only is now an acceptable methodology for telehealth under the PHE.
- For CPT 99441 – 99443, parity face to face rates are applied.
- The 7 days prior/24 hours after bundling logic still applies.
- No codes for audio E/M visits that extend beyond 30 minutes.
- The Telehealth Covered Code List designates a number of codes outside of telephone E/M codes that may be covered under audio only during the PHE.
- POS 02 is not utilized with the audio only visits.
- 98966 – 98968 may be used by other qualified health professionals.

| Telephone E/M Code | Reimbursement Parity |
|---|---|
| **99441** -Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion | **99212** |
| **99442** - 11-20 minutes of medical discussion | **99213** |
| **99443** - 21-30 minutes of medical discussion | **99214** |

Centers for Medicare and Medicaid Services (2021). COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf [27]

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# When to Choose Telephone or Virtual Care

| Virtual Care: G2012, G2252 | Telephone Visits: 99441-99443 |
|---|---|
| **Purpose**: The G2012 is intended to be a brief check in with the patient, 5-10 minutes of medical discussion. | **Purpose**: The 99441-99443 are telephone codes intended for non-face to face evaluation and management. |
| **Length of Time**: G2012- 5-10 minutes, G2252 – 11-20 minutes | **Length of Time**: 99441 - 5-10 minutes, 99442 - 11-20 minutes, 99443 – 21-30 minutes |
| **Modality**: May be video and audio, or audio only | **Modality**: Telephone audio only |
| **Billable**: When there is no related visit 7 days prior or 24 hours or soonest available appointment after, G2012, G2252 are billable codes. Under traditional billing conditions, these codes are only permitted for existing patients. However, under the PHE, these codes are permitted for use with new and existing patients. | **Billable**: When there is no related visit 7 days prior or 24 hours or soonest available appointment after, 99441-99443 are billable codes. Under normal billing conditions, only permitted for existing patients. Under traditional billing conditions, this code is only permitted for existing patients. However, under the PHE, this code is permitted for use with new and existing patients. |
| **Use For:** Any audio or audio/video call that connects with the patient for any check in or discussion or determine the need for a face-to-face visit. | **Use For:** Audio calls that are intended as evaluation and management style conversations. |
| **Payor Notes:** Under traditional billing conditions, these codes are a covered Medicare benefit. | **Payor Notes:** Under traditional billing conditions, these codes are NOT a covered Medicare benefit and is not covered by some Medicaid plans. They ARE covered under the PHE. |

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# Other Modalities for Telehealth

**Electronic Communication**

- For Physicians, PA, NP, etc.:
  - **99421** - Online/digital management of care, 5-10 minutes of cumulative time
  - **99422** - Online/digital management of care, 11-20 minutes of cumulative time
  - **99423** - Online/digital management of care, 21 or more minutes of cumulative time
- For non-qualified physician services:
  - **G2061** - Online/digital management of care, 5-10 minutes of cumulative time
  - **G2062** - Online/digital management of care, 11-20 minutes of cumulative time
  - **G2063** - Online/digital management of care, 11-20 minutes of cumulative time

**Virtual Care**

- **G2010** - Brief communication technology-based service, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **G2012** - Remote evaluation of recorded video and/or images submitted by an established patient (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 can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

**Remote Patient Monitoring**

- **99453:** Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), plus initial set-up and patient education on use of equipment. (Initial set-up and patient education of monitoring equipment included; do not report 99453 for monitoring of less than 16 days.)
- **99454:** Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient.)
- **99457:** Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month, requiring interactive communication with the patient/caregiver during the month; first 20 minutes.
- **99458:** Each additional 20 minutes (List separately in addition to code for primary procedure.)
- **99091:** Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring), digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.

**Interprofessional Communication**

- **99446** -Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review
- **99447** - 11-20 minutes of medical consultative discussion and review
- **99448** - 21-30 minutes of medical consultative discussion and revie
- **99449** - 31 minutes or more of medical consultative discussion and review
- **99451** - Interprofessional telephone/Internet/electronic health assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes of medical consultative discussion and review
- **99452** - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/ requesting physician or other qualified health care professional, 30 minutes

**Communications Based Technology Services**

- **G2251** · Brief communication technology-based service, virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5?10 minutes of clinical discussion
- **G2252** · Brief communication technology-based service, virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion



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# Up Next: The OIG Follow Up Plan

New changes bring new scrutiny. Be prepared for upcoming OIG audits focused on Telehealth.

Plans already announced include:

- Part B Psychotherapy Services provided during the PHE.
- Part B Telehealth Services provided during the PHE, such as annual wellness, electronic visits, remote monitoring, opioid use management, ESRD, virtual care.
- Home Health Services provided during the PHE.
- Telehealth Services for Behavioral Health with Medicaid Managed Care plans.


OIG Work Plan (2021). https://oig.hhs.gov/reports-and-publications/workplan/index.asp



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# Final Thoughts, Questions?

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# Helpful Links and References


American Medical Association (2020). Telehealth During the COVID-19 PHE and FAQS. https://www.ama-assn.org/system/files/2020-05/telemedicine-during-phe-faqs.pdf

American TeleMedicine Association. http://www.americantelemed.org/home

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Centers for Medicare and Medicaid Services (2021). COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing. https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

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