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CMS 2021Telehealth Coding Updates

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Your Presenter

Marla Dumm CPC, CCS-P, CRC
Managing Consultant

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Key Learning Objectives

1. Telehealth Waivers - Status
2. Telehealth and Virtual Communication Updates for 2021
3. Pre and Post COVID-19 – What to Consider

CMS Final Rule Updates for Telehealth

RHC Telehealth Waiver Reminders

- *CMS MLN Matters SE20016 (Updated 12/3/2020)*
  - RHCs will be paid for distant site telehealth (professional) services "for the duration of the COVID-19 PHE"
  - "Any health care practitioner" working for the RHC may render services that are *approved Medicare distant site services* and within the practitioner's scope of practice.
  - The current list of approved telehealth services was updated 12/02/2020
    - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telehealth Background

- Regulatory processes established in CY 2003 to add or remove services from CMS Telehealth List
- Requested additions are reviewed by CMS and assigned a category through notice and comment period
- CMS implemented new categories of telehealth services effective in 2021
  - **Category 1**: Services that are similar to professional consultations, office visits and office psychiatry services currently on the Medicare telehealth list and are considered permanently on the list

Category 1 and Category 3 Telehealth Services

- **Category 1** - codes added to Medicare Telehealth Services List
  - Group Psychotherapy (CPT code 90853)
  - Psychological and Neuropsychological 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)
  - Prolonged Services (HCPCS code G2212)
- **Category 2**: Services that are NOT similar to those on the current Medicare telehealth list, but are permanently added

Category 3 Telehealth Services

- Temporary services added to the Medicare telehealth list during the public health emergency (PHE) for COVID-19 that will remain on the list through the calendar year in which the PHE ends.

  - End-stage Renal Disease Codes: 90952, 90953, 90956, 90959, 90962
  - Emergency Department Visits: 99281, 99282, 99283, 99284, 99285
  - Domiciliary/Rest Home/Custodial Care Services: 99336, 99337
  - Home Visits, Established Patients: 99349, 99350
  - Nursing Facility Discharge Day Management: 99315, 99316
  - Psychological and Neuropsychological Testing: 96121, 96130, 96131, 96132, 96133, 96136, 96137, 96138, 96139
  - Therapy Services: 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521, 92522, 92523, 92524, 92507
  - Subsequent OBS/OBS Discharge Day Management: 99217, 99224, 99225, 99226
  - Initial Hospital Care/Discharge Day Management: 99221, 99222, 99223, 99238, 99239
  - Critical Care Services: 99291, 99292
  - Inpatient Neonatal/Pediatric Subsequent Critical Care: 99469, 99472, 99476
  - Continuing Neonatal Intensive Care: 99478, 99479,99480

Telehealth Post COVID-19 PHE

- Flexibilities set to expire at the conclusion of the Public Health Emergency for COVID-19
  - Relaxed requirement that patient be located in underserved area
  - Relaxed requirement for originating site, including patient home
- Confirmed “real-time audio/visual communication” requires use of both audio and video technology
- Not continuing to pay for audio only calls
  - CMS will create a new G code (G2252), effective after the PHE ends, for “11-20 minute audio-only” to be allowed for an encounter when the physician/practitioner may not be able to have an encounter to visualize the patient.”
  - CMS will be tracking the new G code for utilization
    - Source: *MPFS 2021 Final Rule*
- Patient & Practitioner in same location, this is NOT reported as telehealth
  - This is a current guidelines, but often billed in error
- 2021 Payment rate for G2021 ???

RHC Telehealth Waiver Reminders

- Until the end of the public health emergency, RHCs will continue to report HCPCS code G2025 for distant site telehealth services.

Table 2. RHC Claims for Telehealth Services starting July 1, 2020

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

- Payment will still be made under the Physician Fee Schedule allowance.
- UPDATE: CMS has made adjustment to payments for G2025. The *12/3/20 update of SE20016* stated "for CPT and HCPCS codes included in the list of telehealth codes…we'll adjust the coinsurance and payment calculation for distant site telehealth services…to reflect the method used to calculate coinsurance and deductible and payment under the PFS."
  - Patient coinsurance will be 20% of the lesser of the allowed amount (2020 allowance/$92.03) or actual charges. CMS will pay 80% of the lesser of the allowed amount or the actual charges.
  - Prior to the adjustment, coinsurance for RHC services is calculated at 20% of the actual charges and the CMS payment was the allowed amount (2020/$92.03) minus the coinsurance.
  - MACs automatically began reprocessing any claims with G2025 for services furnished on or after 1/27/2020 through 11/16/2020 that were paid prior to the CMS system update.

RHC Cost Report Waivers

- CMS will not use costs for furnishing distant site telehealth services toward the RHC all-inclusive-rate (AIR)
- Costs are reported on the proper cost report form
  - Originating and Distant site telehealth costs / Form CMS-22-17 on line 79 of Worksheet A, under “Cost Other than RHC Services”
- Any managed care “wrap” payments do not apply to telehealth services

Definitions

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 5 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

Billing and Coding Reminders -Telehealth Visits

Definition – Originating Site HCPCS Q3014

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

- No restrictions on originating site or location
- Patient home will continue to be an eligible originating site through end of the PHE
- Patient may be located anywhere, not just in a MSA, HPSA or nonurban location
- Patient may still present to an eligible health care site
- Changes to the definition of originating site effective March 6, 2020
- Hospital's can submit patient home addresses as part of an application for a "temporary extraordinary circumstance relocation exception" if they want to capture outpatient provider-based site facility charges for the audiovisual telehealth service

Originating Site – If Patient is at Home

- Based on CMS guidance issued 4/30/20
- "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.
  - Eligible Scenario: when the patient is at home with distant site professional service rendered by a practitioner in the provider-based clinic or hospital department
- Q3014 would be submitted on the hospital outpatient UB-04
- Revenue code would be assigned for the site where the patient would have been seen (i.e., 510-clinic)
- Payment will be the same fee schedule allowance of $26.65

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

Audiovisual Telehealth Distant Site Services – Billing for Part B Setting

Billed on a CMS-1500 claim form

Must be an eligible professional service on the CMS telehealth code list and 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 non-facility fee schedule allowance

Phone Only E/M Telehealth Distant Site Services – Billing for Part B Setting

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 non-facility fee schedule allowance

Audiovisual Telehealth Distant Site – Billing for RHC Professional Services *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 for 2021 (still pending)

Telephone or Audio Only E/M Telehealth Services

- Effective March 1, 2020, a RHC can also map the phone only CPT code(s) to n **HCPCS code G2025 for phone/audio only E/M services**
  - Reimbursement calculated to include average of fee schedule allowance for 99441-99443
- "At least 5 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"**
  - **May not be billed for a new patient visit if phone or audio only**
- May not be billed if "originating 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"
- Reimbursement will be at the fee schedule allowance

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)

Visual Aids – Claim Detail

Waiving Cost Sharing for Telehealth

- 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 and then the MAC will automatically reprocess claims beginning July 1, 2020 for the full allowance

*MLN Matters SE20011

Can a Provider Bill for Telehealth or Virtual/Digital Communication if Working from Home?

12. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their homes. The practitioner is not required to update their Medicare enrollment with the home location. The practitioner should list the home address on the claim to identify where the services were rendered. The discrepancy between the practice location in the Medicare enrollment (clinic/group practice) and the practice location identified on the claim (provider's home location) will not be an issue for claims payment.

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

Virtual Check-In – RHC

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

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

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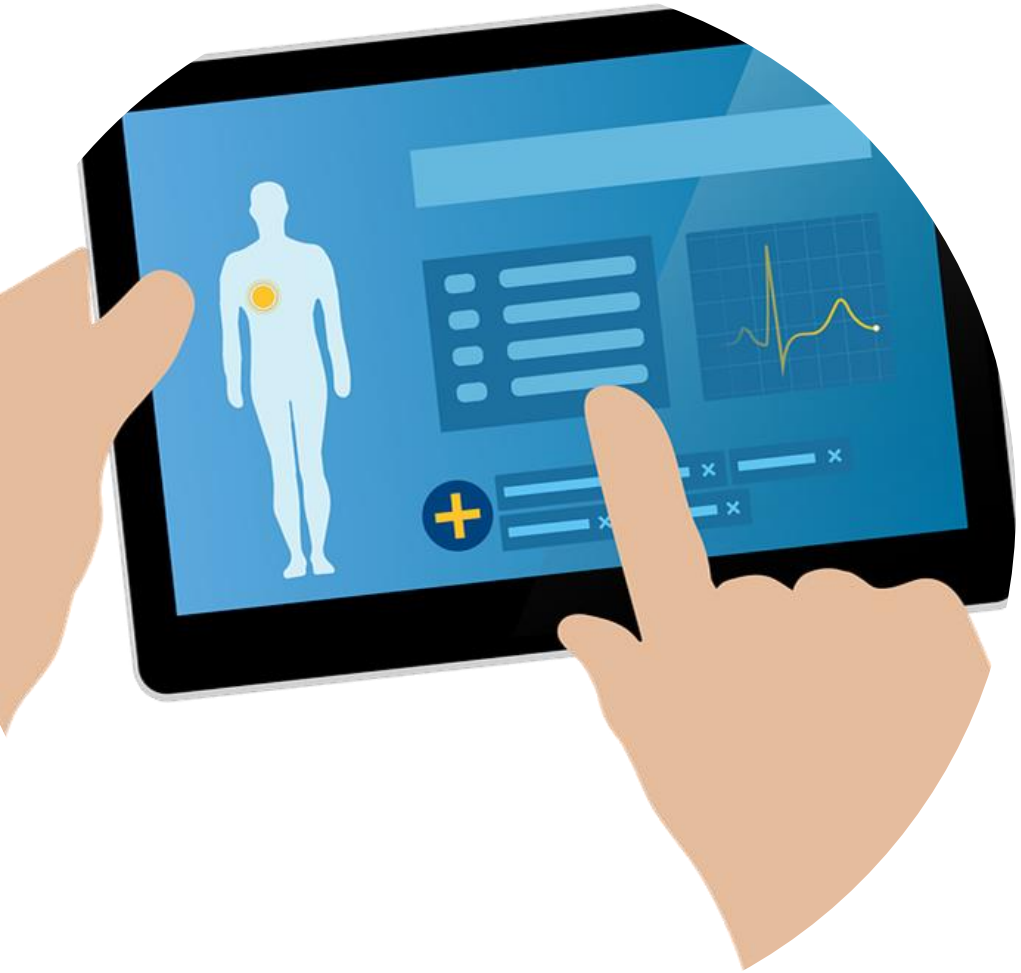
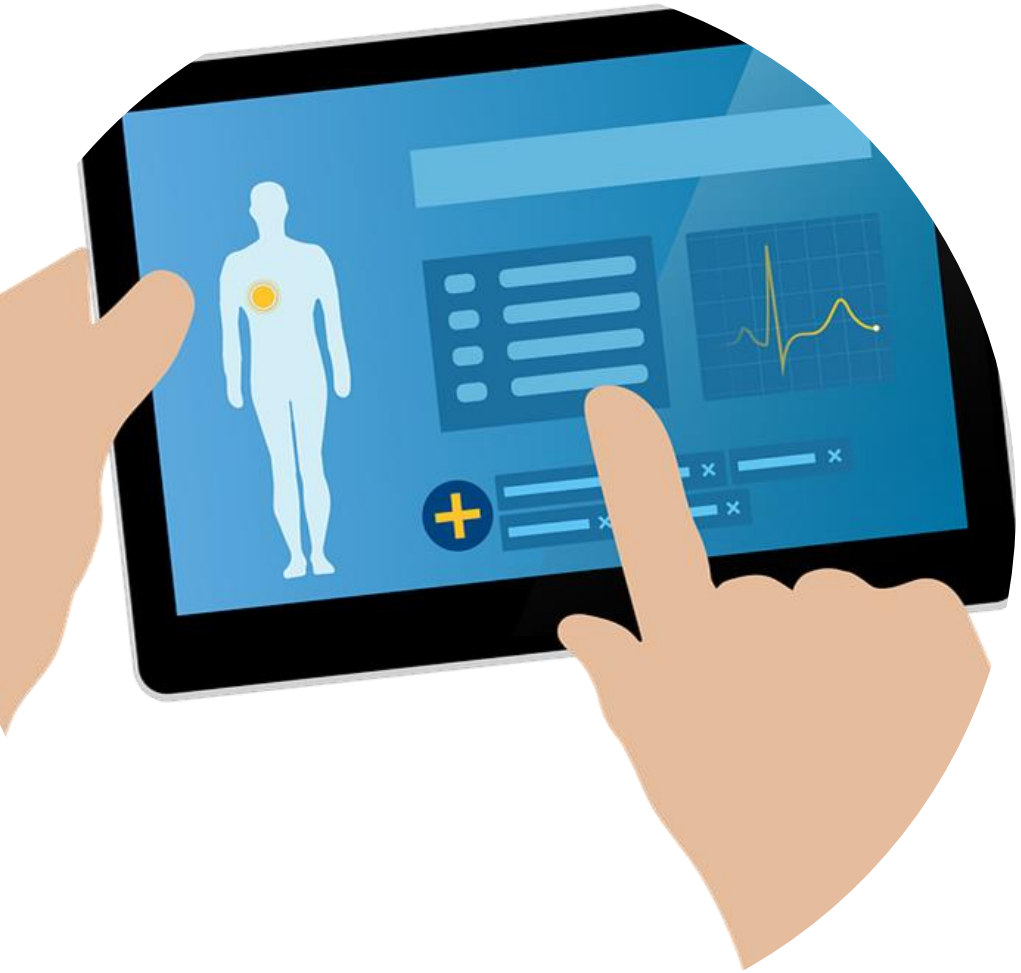
Digital E-Visits – Part B



- Online digital E/M service, *e.g.*, portal
- 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
- CPT Digital visit codes 99421 (5-10”), 99422 (11-20”) & 99423 (21”+) were added as part of the care options outlined in the Interim Final Rule for the emergency period,



Digital E-Visits – RHC

- Online digital E/M service, *e.g.*, portal
- 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 G0071 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
- CPT Digital visit codes 99421, 99422 & 99423 were added as part of the care options outlined in the Interim Final Rule for the emergency period, **BUT are not eligible to separately report in the RHC or FQHC setting for primary Medicare**
- **RHCs report HCPCS code G0071**

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

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

Reimbursement – G0071

- RHCs report G0071 for
  - Virtual e-checks
  - Digital visits
- Reimbursement is under the Medicare Physician Fee Schedule as outlined in the 2019 Physician Fee Schedule Final Rule
- For the emergency period effective March 1, 2020, CMS will pay the average of the fee schedule allowance for G2010, G2012, 99241, 99242 & 99243, or **$24.76**

How Will We Bill for Other Payors?

- Each *state Medicaid* plan has distinct instruction, to include place of service (POS) code criteria, *i.e.*, 02-telehealth, 11-office, & modifiers, *i.e.*, GT, 95
- Each commercial & MCO/HMO plan has distinct instruction, located on their main website

Thank You!

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Marla Dumm, CPC, CCS-P, CRC
Managing Consultant
417.865.8701
mdumm@bkd.com

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