Telehealth Pop-up Webinar – Part B & Non-RHC
Healthcare Business Specialists
Sponsored by Azalea Health and ChartSpan
April 11, 2020
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RHC Information Exchange Group on Facebook
• "A place to share and find information on RHCs."
RHC Information Exchange Group on Facebook

Join this group to post or ask questions regarding RHCs. Anyone is welcome to post about meetings, seminars, or things of interest to RHCs.

https://www.facebook.com/groups/1503414633296362/
• What does Healthcare Business Specialists do?
• Listing of Services

https://tinyurl.com/w63xbp9

• We prepare Medicare and Medicaid Cost Reports for Rural Health Clinics.
• We prepare Program evaluations of RHCs.
• We help clinics startup as RHCs.
• Emergency Preparedness for RHCs.
• We prepare TennCare Quarterly Reports

• Our Cost Reporting Brochure can be found at the following link:

• RHC Cost Report Brochure
For Updates, a recording of this webinar, slide presentations, and lots of information on RHCs and COVID-19 go to our COVID-19 Website

http://www.ruralhealthclinic.com/covid19
Disclaimer

- Due to COVID-19 Healthcare Policy is changing rapidly, waivers are being issued, guidance is being backdated, issued and retracted, official documents are out of date almost as soon as they are issued, so proceed with caution. Some of our resources will contain outdated information, but most of the information is still relevant. The trick and frustrating part is knowing what changed and when. This presentation was prepared on April 11, 2020 and we believe it to be current as of that date, but we could have missed something. If you know of an omission or change, please let us know and we correct it.
Telehealth
Telehealth is Changing the way healthcare is delivered
The Purpose of this webinar is to help RHCs adapt to change caused by COVID-19 and the need to rapidly adopt Telemedicine by RHCs
COVID-19 is changing the speed at which Telehealth is adapted
We will be talking mostly about Medicare rules which do not always apply to other payers

He who has the Gold Makes the Rules

Don’t let the tail wag the Dog

https://www.cchpca.org/resources/covid-19-related-state-actions
Insurance Payment Guidance

Create a Cheat sheet


Current State Laws & Reimbursement Policies

COHP helps you stay informed about telehealth-related laws, regulations and Medicaid programs. The map and search options below cover current laws and regulations for all fifty states and the District of Columbia. The information provided is only for research and informational purposes and should not be construed as legal counsel. Please consult with an attorney if you are seeking a legal opinion. To view the full report, visit the State Report PDF.

Current State Laws & Reimbursement Policies

Search by Filter
- All 50 States & D.C.
- All Categories
- All Topics

Search by Keyword

Data Last Updated Oct 15, 2019

What is a 1135 Public Health Emergency (PHE)

• When the President declares a major disaster or an emergency under the Stafford Act or an emergency under the National Emergencies Act, and the HHS Secretary declares a public health emergency, the Secretary is authorized to take certain actions in addition to his regular authorities under section 1135 of the Social Security Act. He may waive or modify certain Medicare, Medicaid, Children’s Health Insurance Program (CHIP) and Health Insurance Portability and Accountability Act (HIPAA) requirements as necessary to ensure to the maximum extent feasible that, in an emergency area during an emergency period, sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act (SSA) programs and that providers of such services in good faith who are unable to comply with certain statutory requirements are reimbursed and exempted from sanctions for noncompliance other than fraud or abuse.

https://www.phe.gov/Preparedness/legal/Pages/1135-waivers.aspx
Where can I find more information on Telehealth Policies, Laws, and Regulations (start at the 55th minute)

https://www.cchpca.org/

https://www.youtube.com/watch?v=HtMYM9zdqM0&t=4648s

https://www.youtube.com/watch?v=jRpXYsy0Gu0&fbclid=IwAR1wOin84NbsVpOCGdJwFpAyYxJYxBnZWNKGHM_YRPfDsMVOpUXZ-pcmC2g
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Can Out of State physicians furnish Telehealth Services?

https://www.covid19.polsinelli.com/telehealth
Starting a Telehealth Program
Find a Telehealth Toolkit

https://www.ruralhealthinfo.org/toolkits/telehealth
General Provider Telehealth and Telemedicine Tool Kit

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intent of toolkit:

Under President Trump’s leadership to respond to the need to limit the spread of community COVID-19, the Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President’s emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of the broader effort by CMS and the White House Task Force to ensure that all Americans – particularly those at high risk of complications from the virus that causes the disease COVID-19, are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to control the community spread of this virus.

Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient’s places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Note, this toolkit is designed to provide information only and not intended to endorse any non-federal entities.

Using Telehealth to Care for Patients During the COVID-19 Pandemic

Using Telehealth to Care for Patients During the COVID-19 Pandemic

Telemedicine and virtual care have quickly become important tools in caring for your patients while keeping yourself and your staff safe as the COVID-19 pandemic quickly evolves. Here’s what you need to know when providing telehealth services.

How Do I Quickly Implement Telemedicine in My Practice?

- Download the AAFP Surgical Telemedicine Toolkit (pdf) and version 3.
- Review this AAFP Telemedicine Quick Start Guide (pdf) and version 1.

Expansion of Telehealth and Licensing Waivers During the COVID-19 Pandemic

- New Telehealth & License Exemptions Dashboard (newexemptions.aafp.org)

How Do I Get Reimbursed?

The Centers for Medicare & Medicaid Services (CMS) has sharpened the regulations for telemedicine in response to the COVID-19 pandemic. Telehealth services may now be delivered to Medicare beneficiaries to choose as long as video capability is available.

Fighting for Family Medicine: AAFP Advocates for CMS to Relax Key Regulations

- Working with CMS to speed up telehealth regulations.
- Help with the CMS General Telemedicine Toolkit.

Selecting Technology for Use

- Accessing the AAFP’s Telemedicine to Care for Patients in the COVID-19 Pandemic guide.

Key Questions You Will Want to Answer When Exploring Telehealth Platforms

- The AAFP is gathering answers to these questions across vendors:
  - Can I edit my contract at any time (i.e., not locked into a 2-year contract)?
  - Is there a waiting room feature so I can queue my patients up?
  - Is the platform device agnostic (i.e., can physician/providers and patients use device of their choosing for virtual care)?
  - Is there an out-of-office messaging where we’re not available to take your call (right now)? i.e., during off hours or overnight?
  - Does the software have the ability to schedule a visit? Note: This is a more advanced feature; it’s not absolutely required to have over, but it’s very nice to have.
  - Is the platform deployable in days?

Medicare Telehealth Services

- Are provided using telecommunication technology and include office, hospital, or other services that generally occur in-person. A list of Medicare telehealth services is accessible.

- Should be billed with the Place of Service (POS) code “02.”
- Should be billed with the same as in-person visits and at the same rate as in-person visits.

- Can be provided at established Medicare patient sites if phone allows for audio-visual interaction between the physician and patient.
- Established patient means a Medicare patient seen either by you or another physician or provider within the same practice within the last three years.
- The Department of Health and Human Services (HHS) has announced that it will not conduct public (nonmedical) to ensure a fair relationship avoided for claims submitted during the COVID-19 public health emergency.

- Can be provided in all settings, including a patient’s home. Complete list of services has been released publicly.
- The HHS Office of Inspector General (OIG) is allowing practices for non-emergency services for telehealth.

Medicare Non-Telehealth Services

- Medicare Virtual Check-ins (02212)
  - Eligible for a quick visit with an established patient to determine if an in-person visit is necessary.
  - Are brief (5-15 minutes) conversations with a physician or other health care provider.
  - The communication is not required to be a medical visit within the previous seven days and does not lead to a medical visit within the next 24 hours (or, if appointment available).

- Can be conducted through multiple communication technology modalities, including:
  - Synchronous telehealth conversation
  - Exchange of information through voice or image
  - Physician or other clinician may be telephoned by patient, audio/video, secure texting, messaging, email, or use of patient portal.

  - Is reimbursed by the patient and patient must provide verbal consent.
  - Is subject to insurance and deductibles.

- eConsult can be used when a captured video or image is sent to the physician. The physician must follow-up within 24 business hours. The consultation must not originate from an evaluation and management (E&M) service provided within the previous seven days and does not lead to an E&M service within the next 24 hours (or, if appointment available).

Medicare E-Valts (online digital evaluation and management services)

Think through the how to conduct a Telemedicine visit before doing one. Practice internally before going live

• Telehealth and Telephone Visits in the Time of COVID-19: FQHC Workflows and Guides

*Phone Call Script*

* Hello, this is [employee name] from Clínicas de Salud del Pueblo, calling to confirm your appointment for tomorrow at [TIME], your provider will be doing a telephone consultation. You are not required to come to the clinic at this time due to the pandemic (Corona virus).

**Hola, mi nombre es _____ llamo de Clínicas de Salud del Pueblo para confirmar su cita de mañana a las ________, su cita será una consulta vía teléfono. Usted no requiere venir a la clínica durante este momento debido a la pandemia (Corona virus).**
The secret to creativity is knowing how to hide your sources

~ Albert Einstein ~

We make no attempt to hide our sources
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<td>UCA</td>
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<td><a href="https://useast-noah.informz.net/informabledataservice/onlinerversion/ind/b/WFyT6g2uc33rhjvN2bQ0T2bEMcGM2e6vz3p3yimiyawQ8MTE2NjI=">https://useast-noah.informz.net/informabledataservice/onlinerversion/ind/b/WFyT6g2uc33rhjvN2bQ0T2bEMcGM2e6vz3p3yimiyawQ8MTE2NjI=</a></td>
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<td>Telehealth</td>
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CMS is backdating some of the guidance – Watch your dates- You may need to refile claims.
CMS Expands the use of Telehealth during the period of the PHE

KEY TELEHEALTH TAKEAWAYS

• Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.

• These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

• Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
Key Telehealth Takeaways (2)

• While they must generally travel to or be located in certain types of originating sites such as a physician’s office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home. (No longer restricted to originating sites)

• The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

• To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. (New patients are allowed during the duration of the National Emergency.)
As of March 16, 2020, HHS and the DEA, in accordance with the public health emergency exception, will allow Schedule II-V controlled substances to be prescribed to patients, even when an in-person medical evaluation has not been conducted, if the following conditions are met:

• The prescription is for a legitimate medical purpose by a practitioner acting in the usual course of their professional practice
• The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and
• The practitioner is acting in accordance with applicable Federal and State laws.

https://www.deadiversion.usdoj.gov/coronavirus.html
Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19 – March 30, 2020

- 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.

Why Medicare Patients are slow to adopt Telemedicine
Medicare is Falling Behind

Medicare  Commercial Insurance  Medicaid
How Medicare RHC Regulations have slowed the growth of Telehealth

The Patient must be located at specific originating sites (except during State of Emergency)

RHCs can not be Distant Sites (except during State of Emergency)

Telehealth costs are not used to compute the AIR.
Originating Sites for Telemedicine can now be in urban areas and can be initiated from a patient’s home.
Medicare Originating Sites

ORIGINATING SITES

An originating site is the location where a Medicare beneficiary gets physician or practitioner medical services through a telecommunications system. The beneficiary must go to the originating site for the services located in either:

- A county outside a Metropolitan Statistical Area (MSA)
- A rural Health Professional Shortage Area (HPSA) in a rural census tract

The Health Resources and Services Administration (HRSA) decides HPSAs, and the Census Bureau decides MSAs. To see a potential Medicare telehealth originating site’s payment eligibility, go to HRSA’s Medicare Telehealth Payment Eligibility Analyzer.

Providers qualify as originating sites, regardless of location, if they were participating in a Federal telemedicine demonstration project approved by (or getting funding from) the U.S. Department of Health & Human Services as of December 31, 2000.

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removes the originating site geographic conditions and adds an individual’s home as a permissible originating telehealth services site for treatment of a substance use disorder or a co-occurring mental health disorder.

Waived duration of National Emergency
Each December 31 of the prior calendar year (CY), an originating site’s geographic eligibility is based on the area’s status. This eligibility continues for a full CY. Authorized originating sites include:

- Physician and practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural Health Clinics
- Federally Qualified Health Centers
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Skilled Nursing Facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal Dialysis Facilities
- Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis
- Mobile Stroke Units

Note: Medicare does not apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes when practitioners furnish monthly home dialysis ESRD-related medical evaluations. Independent Renal Dialysis Facilities are not eligible originating sites.

Beginning January 1, 2019, the Bipartisan Budget Act of 2018 removed the originating site geographic conditions and added eligible originating sites to diagnose, evaluate, or treat symptoms of an acute stroke. Go to MLN Matters® article, New Modifier for Expanding the Use of Telehealth for Individuals with Stroke to learn how to use the new modifier for billing.

Waived duration of National Emergency
Providers furnishing telehealth services from home do NOT have to call Part B and add their home address to their Medicare Enrollment.

This answer was removed from the most recent FAQ.

11. 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 for distant site practitioners furnishing Medicare telehealth services from their home. The practitioner must still have a Medicare provider number, whether a clinic or home location. The practitioner should report the home address on their Medicare provider enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction’s provider enrollment hotline. It would be unnecessary for practitioners starting care without a disruption to Medicare enrollment requirements if the location of the clinic/group practice is found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigned their Medicare benefits to a clinic/group practice, then the clinic/group practice is required to update their Medicare enrollment with their home location. The clinic/group practice can add the individual’s home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

Is Telehealth here to Stay?

VIRTUAL CARE IS THE FUTURE
Technically RHCs provide a Part B service funded through the Part B Trust Fund and paid through a Medicare Part A Cost-Based Reimbursement Methodology.
TELEHEALTH & TELEMEDICINE

- What is the difference between Telehealth and Telemedicine?
  
  - Telehealth can either refer to clinical and/or non-clinical services.
  - Telemedicine only refers to the provision of clinical services.
**Synchronous Telehealth**

- Real-time Video
- Online Discussion Groups

**Asynchronous Telehealth**

- File Sharing
- Secure Texting
- Outcome Tracking
- Audio Clips
- Alerts
- Email
- Exercise Videos

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**synchronous** adjective

\[\text{syn-chro-nous} \quad \text{ˈsɪn-kro-nəs}\]

**Definition of synchronous**

1. happening, existing, or arising at precisely the same time
2. recurring or operating at exactly the same periods

**asynchronous** adjective

\[\text{asyn-chro-nous} \quad \text{ˈaɪn-krə-nəs}\]

**Definition of asynchronous**

1. not simultaneous or concurrent in time: not synchronous
   \( /əˈsɪn-kroʊ-nəs\)
How to bill Telehealth to Medicare Part B, Fee for Service
Telehealth Services in Provider Homes and during Non-RHC Hours
Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

The Trump Administration is issuing an unprecedented array of temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the 2019 Novel Coronavirus (COVID-19) pandemic. Made possible by President Trump’s recent emergency declaration and emergency rule making, these temporary changes will apply immediately across the entire U.S. healthcare system for the duration of the emergency declaration. The goals of these actions are to 1) ensure that local hospitals and health systems have the capacity to handle a potential surge of COVID-19 patients through temporary expansion sites (also known as CMS Hospital Without Walls); 2) remove barriers for physicians, nurses, and other clinicians to be readily hired from the community or from other states so the healthcare system can rapidly expand its workforce; 3) increase access to telehealth in Medicare to ensure patients have access to physicians and other clinicians while keeping patients safe at home; 4) expand in-place testing to allow for more testing at home or in community based settings; and 5) put Pregnant Women at Risk to receive temporary relief from many paperwork, reporting and audit requirements so providers, health care facilities, Medicare Advantage and Part D plans, and States can focus on providing needed care to Medicare and Medicaid beneficiaries affected by COVID-19.

Medicare Telehealth

Clinicians can now provide more services to beneficiaries via telehealth so that clinicians can take care of their patients while mitigating the risk of the spread of the virus. Under the public health emergency, all beneficiaries across the country can receive Medicare telehealth and other communications technology-based services wherever they are located. Clinicians can provide these services to new or established patients. In addition, providers can waive Medicare copayments for these telehealth services for beneficiaries in Original Medicare.

To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327-99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347-99350)
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475-99476)

- Initial and Continuing Intensive Care Services (CPT code 99477-994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Radiation Treatment Management Services (CPT codes 77427)
- Licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

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

Virtual Check-Ins & E-Visits

- Additionally, clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966-98968, 99441-99443)

Remote Patient Monitoring

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

Removal of Frequency Limitations on Medicare Telehealth

To better serve the patient population that would otherwise not have access to clinically appropriate in-person treatment, the following services no longer have limitations on the number of times they can be provided by Medicare telehealth:

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

**Medicare Physician Supervision requirements:** For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

Other Medicare Telehealth and Remote Patient Care

- For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site.
- For Medicare patients with ESRD, we are 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 National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.
- 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.

Workforce

- Medicare Physician Supervision requirements: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.
- Medicare Physician Supervision and Auxiliary Personnel: The physician can enter into a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26, including with staff of another provider/supplier type, such as a home health agency (defined under § 1861(o)(3)(D)), or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians’ service (including services that are allowed to be performed via telehealth). In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.
- Medicare Physician Supervision requirements: Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.
- Physician Services: CMS is waiving 482.12(c)(1)-(4), which requires that Medicare patients in the hospital be under the care of a physician. This allows hospitals to use other practitioners, such as physician’s assistant and nurse practitioners, to the fullest extent possible. This waiver should be implemented in accordance with a state’s emergency preparedness or pandemic plan.
- National coverage determinations (NCDs) and Local Coverage Determinations (LCDs): To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this public health emergency, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions.
Medicare Coverage and Payment of Virtual Services Video Released April 3, 2020

https://www.youtube.com/watch?v=db9NKtybzo&feature=youtu.be
What are the types of virtual services?

- Medicare telehealth visits
- Virtual check-ins
- E-visits
- Telephone Services
# Part B - Summary of Medicare Telehealth Services

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>WHAT IS THE SERVICE?</th>
<th>HCPCS/CPT CODE</th>
<th>Patient Relationship with Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MEDICARE TELEHEALTH VISITS</strong></td>
<td>A visit with a provider that uses telecommunication systems between a provider and a patient.</td>
<td>Common telehealth services include:</td>
<td>For new* or established patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 99201-99215 (Office or other outpatient visits)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G0425-G0427 (Telehealth consultations, emergency department or initial inpatient)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>For a complete list:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes">https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Interim Final Regulation added 85 new codes</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VIRTUAL CHECK-IN</strong></td>
<td>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 established patient.</td>
<td>• HCPCS code G2012</td>
<td>For established patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• HCPCS code G2010</td>
<td>New is <strong>ok</strong> during PHE</td>
</tr>
<tr>
<td><strong>E-VISITS</strong></td>
<td>A communication between a patient and their provider through an online patient portal.</td>
<td>• 99421</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 99422</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 99423</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G2061</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G2062</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• G2063</td>
<td></td>
</tr>
<tr>
<td><strong>Telephone</strong></td>
<td><strong>Interim Final Regulation added 6 new codes</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*To the extent the 1135 waiver requires an established relationship, HCBS will not conduct audits to ensure that such a relationship existed for claims submitted during this public health emergency.
Medicare Recognizes Four Types of Telemedicine

Effective March 6, 2020 and for the duration of the Public Health Emergency

### Telehealth
1. Audio and Video
2. Expanded to include all areas and all settings
3. Applicable to new and established patients
4. Medicare Copays and deductibles apply however OIG will allow flexibility for providers to reduce or waive fees during the PHE
5. Payment is changed to then non-facility fee schedule if performed in the office (POS 11, Modifier 95)
6. Consent to treat needs to be obtained*

### Virtual Check-Ins
1. Phone Calls
2. No Geographic or location restrictions
3. Applicable only to established patients (New is Ok during PHE)
4. Medicare Copays and deductibles apply except when treating COVID
5. Consent to treat needs to be obtained*
6. Part B codes are G2012 or G2010 & RHCs use G0071

### E-Visits
1. Patient Portal
2. No Geographic or location restrictions
3. Applicable only to established patients. (New is Ok during PHE)
4. Medicare Copays and deductibles apply except when treating COVID
5. Consent to treat needs to be obtained*
6. Individual services need to be initiated by the patient, but practitioner may educate beneficiaries of availability of the service.

### Telephone
1. Prolonged Phone Calls
2. Part B Codes are 98966-98968 for Non-Physicians and 99441-99443 for physicians
3. Similar to virtual check-ins
4. Physical Therapist, Speech Pathologists, Occupational Therapists
5. Applicable only to established patients (New is Ok during PHE)
6. Medicare Copays and deductibles apply except when treating COVID
7. Consent to treat needs to be obtained*
WAIT
WHAT????
What are Telehealth Services?
Who can provide telehealth services?

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Certified nurse anesthetists

- Clinical psychologists
- Clinical social workers
- Registered dietitians
- Nutrition professionals
Which Practitioners can perform Telehealth
Public Health Emergency – 1135 Waiver

Waiver expanded list of eligible providers to provide services and be reimbursed

- Eligible providers are:
  - Physicians
  - Nurse practitioners
  - Physician assistants
  - Nurse-midwives
  - Clinical nurse specialists
  - Certified registered nurse anesthetists
  - Clinical psychologists (CP)
  - Clinical social workers (CSWs) (NOTE: 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 CPT codes 90792, 90833, 90836, and 90838)
  - Registered dietitians or nutrition professional
  - Physical Therapists
  - Occupational Therapists
  - Speech Language Pathologist
Interim Final Regulation added 85 new Telehealth Codes in two categories on March 30, 2020 effective March 1, 2020

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. We also look for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.

Category 2: Services that are not similar to those on the current list of telehealth services. Our review of these requests includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. Our evidentiary standard of clinical benefit does not include minor or incidental benefits.

CMS Expanded the number of payable Medicare Part B Telehealth services from 101 to 191

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
<table>
<thead>
<tr>
<th>Code</th>
<th>Short Descriptor</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>77427</td>
<td>Radiation tx management x5</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90765</td>
<td>Psycho complex management</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90791</td>
<td>Psych-diagnostic evaluation</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90792</td>
<td>Psych Rx complex interactive</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90793</td>
<td>Psych diagnostic evaluation</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90794</td>
<td>Psych diag eval w/med srvcs</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90832</td>
<td>Psytx pt&amp;/family 30 minutes</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90833</td>
<td>Psytx pt&amp;/fam w/e&amp;m 30 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90834</td>
<td>Psytx pt&amp;/family 45 minutes</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90835</td>
<td>Psytx pt&amp;/fam w/e&amp;m 45 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90836</td>
<td>Psytx pt&amp;/family 60 minutes</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90837</td>
<td>Psytx pt&amp;/fam w/e&amp;m 60 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
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<tr>
<td>90838</td>
<td>Psytx crisis initial 60 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
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<tr>
<td>90839</td>
<td>Psytx crisis ea addl 30 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90840</td>
<td>Psytx crisis ea addl 45 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>90841</td>
<td>Psytx crisis ea addl 60 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
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<tr>
<td>90842</td>
<td>Psytx crisis ea addl 120 min</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
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<tr>
<td>92521</td>
<td>Evaluation of speech fluency</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>92522</td>
<td>Evaluation speech production</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>92523</td>
<td>Speech sound long comprbted</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>92524</td>
<td>Behavioral qualit analy tech</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>95110</td>
<td>Psychological status exam</td>
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<tr>
<td>96130</td>
<td>Speech eval psychiatry 1st</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>96131</td>
<td>Speech eval psychiatry ea</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
<tr>
<td>96132</td>
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<td>96133</td>
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<td>96146</td>
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<td>96149</td>
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<td>96150</td>
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<td>96152</td>
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<td>96157</td>
<td>Psych eval psychiatry tech ea</td>
<td>Temporary Addition for the PHE for the COVID-19 Pandemic</td>
</tr>
</tbody>
</table>

**LIST OF MEDICARE TELEHEALTH SERVICES**

Total Codes currently Equal 191 of which 85 are Temporary
Billing for Professional Telehealth Distant Site Services During the Public Health Emergency — Revised

This corrects a prior message that appeared in our March 31, 2020 Special Edition. Even Medicare is having a hard time keeping up.

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 90 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 Public Health Emergency (PHE), bill with:

• Place of Service (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

How does a qualified provider bill for telehealth services during the PHE?

- Place of Service (POS) equal to what it would have been in the absence of a PHE
- Include modifier 95
Important

“We are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. This will allow our 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. Given the potential importance of using telehealth services as means of minimizing exposure risks for patients, practitioners, and the community at large, we believe this interim change will maintain overall relativity under the PFS for similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth. Because we currently use the POS code on the claim to identify Medicare telehealth services, we are finalizing on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth. We note that we are maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose, for whatever reason, to maintain their current billing practices for Medicare telehealth during the PHE for the COVID-19 pandemic.”

Page 15 of Interim Final Regulation released March 30, 2020

https://www.cms.gov/files/document/covid-final-ifc.pdf?fbclid=IwAR0TYjcu5xyUfdNF03mb9AFBgKZmw82s7iE9cCpZ67jzjAKUdnR8utuLy_4
Telehealth Part B Billing Changes due to the Public Health Emergency
Per Interim Final Rule published March 30, 2020 applicable beginning March 1, 2020

**PRE-COVID**

- **Time Frame**: February 28, 2020 & before
- **Place of Service**: 02
- **Payment**: Payment was limited to the facility fee payment schedule.

**PHE**

- **Time Frame**: March 1, 2020 to the end of PHE*
- **Place of Service**: Telehealth Services done in the office Use **POS 11 and Modifier 95**.
- **Payment**: Payment will be the Non-Facility Fee

* CMS removed the restriction on originating sites on March 6, 2020
How much does Medicare pay for telehealth services?

Medicare pays the same amount for telehealth services as it would if the service were furnished in person.
# Place of Service Matters

<table>
<thead>
<tr>
<th>CPT with Description</th>
<th>POS 11 Non-Facility Modifier 95</th>
<th>POS 2 Facility Modifier 95</th>
<th>Variance</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$46.56</td>
<td>$27.07</td>
<td>-$19.49</td>
<td>-41.9%</td>
</tr>
<tr>
<td>99202 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$77.23</td>
<td>$51.61</td>
<td>-$25.62</td>
<td>-33.2%</td>
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<tr>
<td>99203 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$109.35</td>
<td>$77.23</td>
<td>-$32.12</td>
<td>-29.4%</td>
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<tr>
<td>99204 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$167.10</td>
<td>$132.09</td>
<td>-$35.01</td>
<td>-21.0%</td>
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<tr>
<td>99205 OFFICE/OUTPATIENT VISIT NEW</td>
<td>$211.13</td>
<td>$172.51</td>
<td>-$38.62</td>
<td>-18.3%</td>
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<tr>
<td>99211 OFFICE/OUTPATIENT VISIT EST</td>
<td>$23.46</td>
<td>$9.38</td>
<td>-$14.08</td>
<td>-60.0%</td>
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<tr>
<td>99212 OFFICE/OUTPATIENT VISIT EST</td>
<td>$46.20</td>
<td>$26.35</td>
<td>-$19.85</td>
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<tr>
<td>99213 OFFICE/OUTPATIENT VISIT EST</td>
<td>$76.15</td>
<td>$52.33</td>
<td>-$23.82</td>
<td>-31.3%</td>
</tr>
<tr>
<td>99214 OFFICE/OUTPATIENT VISIT EST</td>
<td>$110.44</td>
<td>$80.48</td>
<td>-$29.96</td>
<td>-27.1%</td>
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<tr>
<td>99215 OFFICE/OUTPATIENT VISIT EST</td>
<td>$148.33</td>
<td>$113.68</td>
<td>-$34.65</td>
<td>-23.4%</td>
</tr>
</tbody>
</table>

$1,015.95 | $742.73 | -$273.22 | -26.9%

March 30, 2020 Telehealth Part B Billing Guidance
<table>
<thead>
<tr>
<th>CPT with Description</th>
<th>Non-Facility Fee</th>
<th>Facility Fee</th>
<th>Variance</th>
<th>% Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>99231 SUBSEQUENT HOSPITAL CARE</td>
<td>$40.06</td>
<td>$40.06</td>
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</tr>
<tr>
<td>99232 SUBSEQUENT HOSPITAL CARE</td>
<td>$73.62</td>
<td>$73.62</td>
<td>$0.00</td>
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<tr>
<td>99233 SUBSEQUENT HOSPITAL CARE</td>
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<td>$106.10</td>
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<tr>
<td>G0406 INPT/TELE FOLLOW UP 15</td>
<td>$73.26</td>
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<td>G0407 INPT/TELE FOLLOW UP 25</td>
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<tr>
<td>G0408 INPT/TELE FOLLOW UP 35</td>
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There is no difference in amounts paid to providers for services performed via Telehealth in other settings.
RHC Originating Site Telehealth Billing – Pre-Covid

Example: RHC is originating site and Physician is Distant site

- **Distant Site Provider (Specialist)**
  - Place of Service 02
  - CPT Code 99213
  - $53.33

- **Originating Site (RHC)**
  - Restricted to Certain Rural Areas
  - Revenue Code 0780
  - CPT Code Q3014
  - $26.15

- **Total Medicare Payment**
  - Co-pays and Deductibles apply
  - So payment amount will vary
  - $79.48
Medicare Part B – (Not RHC) Telehealth Billing – Public Health Emergency

Example: Physician provides Telehealth service while located in office

- Medicare Part B Provider
  - In a clinic
  - Place of Service 11, Modifier 95
  - CPT Code 99213
  - $76.15

- No Originating Site
  - Patient can be home
  - Or in urban area
  - $0

- Total Medicare Payment
  - Co-pays and Deductibles apply
  - So payment amount will vary
  - $76.15

Place of Service Code 02 is no longer used during the PHE unless you want to be paid less.
Modifiers used in Telehealth Billing

- **95**
  - Medicare uses this now
  - Synchronous telemedicine rendered via real-time interactive audio & video

- **GT**
  - CAH Method II
  - Used for interactive audio & telemedicine systems. Tells payor that service delivered via telemedicine

- **GQ**
  - Hawaii & Alaska
  - Providers participating in the telemedicine demonstration via asynchronous telecommunications system

- **G0**
  - Acute Stroke
  - Telehealth service for diagnosis, evaluation or treatment of systems of an acute stroke

- **GY**
  - ABN
  - Notice of Liability not issued, not required under payer policy because service is excluded from Medicare benefit.
Elimination of the GT Modifier for Telehealth Services

MLN Matters Number: MM10152
MLN CR Number: CR10152

Prescriber CR Release Date: November 20, 2017
Effective Date: January 1, 2018

Provider CR Issue Date: January 2, 2018

MLN Matters Article: This MLN Matters® Article is intended for providers who submit claims to Medicare

Provider Action Needed: Change Request (CR) 10152 eliminates the requirement to use the GT modifier (via interactive audio and video telecommunications systems) on professional claims for telehealth services. Use of the telehealth Place of Service (POS) Code 02 verifies that the service meets the telehealth requirements.

Background: CR10152 revises the previous guidance that instructed practitioners to submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT for interactive audio and video telecommunications systems. The GT modifier is still required when applicable. As a result of the CR 2017 Physician fee Schedule (PFS) final rule, CR10152 implemented payment policies regarding Medicare’s use of a new POS Code 02 to report services furnished via telehealth. The new POS Code 02 verifies that the service is furnished via telehealth.

Use of the telehealth POS Code confirms that the service meets the telehealth requirements.

Note that for distant site services billed under Critical Access Hospital (CAH) method II on institutional claims, the GT modifier will still be required.

MACs will apply the "one every three days" frequency audit logic for telehealth services when codes 99231, 99232, and 99233 are filed with POS 02 for claims with dates of service January 1, 2018, and after. This requirement is waived when the services are published (unpublished services may be available for claims with dates of service January 1, 2018, and after). The "one every three days" frequency audit logic will not apply to claims with dates of service January 1, 2018, and after. The "one every three days" frequency audit logic will apply to claims with dates of service January 1, 2018, and after. The "one every three days" frequency audit logic will apply to claims with dates of service January 1, 2018, and after.

MACs will apply the existing "one every 30 days" frequency audit logic for telehealth services when codes 99207, 99209, 99216, and 99218 are linked with POS 02 for claims with dates of service January 1, 2018, and after. This frequency audit logic applies when these services are published (unpublished services may be available for claims with dates of service January 1, 2018, and after). The existing "one every 30 days" frequency audit logic will apply to claims with dates of service January 1, 2018, and after.

Additional Information:

- The official instruction issued to your MAC regarding this change is available at https://www.cms.gov/Regulations-Compliance/downloads/MM10152.pdf
- To review the MLN Matters® article related to this CR you may go to https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN MattersArticles/downloads/MM10152.pdf

If you have any questions, please contact your MAC at their toll-free number. That number is available at https://www.cms.gov/Medicare-Enrollment-Forms/Utilizations-Rates/Phone-Numbers.

Document History:

- Date of Change: December 4, 2017
- Initial Article Revised: Initial Article Revised

Disclaimer:

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ANOTHER MODIFIER
Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that: are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE); that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test; and are in any of the following categories of HCPCS evaluation and management codes:
- 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 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)

Not just for Telehealth services
CS Modifier Effective March 18, 2020

When
COVID-19 testing-related services, which are medical visits that are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE)

Where
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, RHCs

What
CS Modifier waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services – Provider paid 100% of rate instead of 80%

How
Add the CS modifier along with the CG Modifier to the Claim & refile or append claims already filed dated with starting with DOS of 3/18/20 till the end of the PHE

Reference
Families First Coronavirus Response Act
Waives Coinsurance and Deductibles for
Additional COVID-19 Related Services

The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for Medicare patients for COVID-19 testing-related services. These services are medical visits for the HCPCS evaluation and management categories described below when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002, or 87635.

Virtual Visits billable for RHCs since January 1, 2019

New Virtual Communication Services

Effective January 1, 2019, RHCs can receive payment for Virtual Communication services when at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient who has had an RHC billable visit within the previous year, and both of the following requirements are met:

- The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days, and
- The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.

To receive payment for Virtual Communication services, RHCs must submit an RHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. Payment for G0071 is set at the average of the national non-facility PFS payment rates for HCPCS code G2012 (communication technology-based services) and HCPCS code G2010 (remote evaluation services) and is updated annually based on the PFS national non-facility payment rate for these codes. See Virtual Communication Services Frequently Asked Questions (PDF).

RHC face-to-face requirements are waived when these services are furnished to an RHC patient, and coinsurance and deductibles apply.

Can be a new patient during the National emergency

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FQHCPPS/Downloads/VCS-FAQs.pdf
Virtual Check-in – Part B

G2010
- Store and Forward evaluation of video or images
- Minutes: 5-10 - $12.24

G2012
- Brief communication technology-based service
- Minutes: 5-10 - $14.80

Each code is up to 7 days cumulative time
Virtual Check-Ins Key Takeaways

- Not limited to rural settings
- Patient must agree to the service
- HCPCS codes G2012 or G2010
- Broader range of communication methods
On an interim basis, during the PHE for the COVID-19 pandemic, we are also broadening the availability of HCPCS codes G2010 and G2012 that describe remote evaluation of patient images/video and virtual check-ins. *We recognize that in the context of the PHE for the COVID-19 pandemic, practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists might also utilize virtual check-ins and remote evaluations* instead of other, in-person services within the relevant Medicare benefit to facilitate the best available appropriate care while mitigating exposure risks. We note that this is not an exhaustive list and we are seeking input on other kinds of practitioners who might be furnishing these kinds of services as part of the Medicare services they furnish in the context of the PHE for the COVID-19 pandemic. Further, to facilitate billing of the CTBS services by therapists for the reasons described above, we are designating HCPCS codes G2010, G2012, G2061, G2062, or G2063 as CTBS CMS-1744-IFC 55 “sometimes therapy” services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services. CTBS therapy services include those furnished to a new or established patients that the occupational therapist, physical therapist, and speech language pathologist practitioner is currently treating under a plan of care.
TIMELINE of a Medicare Virtual Visit

**Look Back Period**
The medical discussion or remote evaluation is for a condition not related to an RHC service provided within the previous 7 days.

**The Virtual Visit**
Represents at least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC practitioner to a patient.

**Going Forward**
*The medical discussion or remote evaluation does not lead to an RHC visit within the next 24 hours or at the soonest available appointment.*
E-visits

Codes for practitioners who *may* bill independently:

- 99421
- 99422
- 99423
E-Visits for Medicare Part B

- **99421**
  - Online digital E & M
  - Minutes: 5-10 - $15.52

- **99422**
  - Online digital E & M
  - Minutes: 11-20 - $31.04

- **99423**
  - Online digital E & M
  - Minutes: 21+ - $50.16

Each code is up to 7 days cumulative time

Online digital evaluation and management service

**Other requirements:**
• Verbal consent is required by CMS.
• The patient initiates the service with an inquiry through the portal
• The service is documented in the medical record.
• If the patient had an E/M service within the last seven days, these codes may not be used for that problem.
• If the inquiry is about a new problem (from the problem addressed at the E/M service in the past 7 days), these codes may be billed.
• If within seven days of the initiation of the online service a face-to-face E/M service occurs, then the time of the online service or decision-making complexity may be used to select the E/M service, but this service may not be billed.
• This is for established patients, per CPT®. – **Waived during PHE.**
• This may not be billed by surgeons during the global period.
• The digital service must be provided via a HIPAA compliant platform, such as an electronic health record portal, secure email or other digital applications. **Waived during PHE.**

Additionally:
• These services may only be reported once in a 7-day period.
• Clinical staff time may not be included.
• Don’t double count time with any other separately reported services, such as care management, INR monitoring, remote monitoring. (CPT® book has a list of codes)
Online digital evaluation and management service

• Report these services once during a 7-day period, for the cumulative time. According to CPT®,

• “The seven-day period begins with the physician’s or other qualified health care professional’s (QHP) initial, personal review of the patient-generated inquiry. Physician’s or other QHP’s cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient’s problem, personal physician or other QHP interaction with clinical staff focused on the patient’s problem, development of management plans, including physician or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent separately reported E/M service.”
E-Visit Key Takeaways

- Not limited to rural settings
- No geographic or location restrictions
- Initiated by the patient
- Practitioners may educate beneficiaries
- Bill using CPT codes 99421-99423 and HCPCS codes G2061-G2063
- Medicare coinsurance and deductible generally apply
Online digital evaluation and management service

- **99421** Online digital evaluation and management service, for an established patient (waived during PHE), for up to 7 days cumulative time during the 7 days; 5-10 minutes
- **99422** 11—20 minutes
- **99423** 21 or more minutes

- These codes are for use when E/M services are performed, of a type that would be done face-to-face, through a HIPAA compliant secure platform. These are for patient-initiated communications, and may be billed by clinicians who may independently bill an E/M service. They may not be used for work done by clinical staff or for clinicians who do not have E/M services in their scope of practice.
Codes for Telephone Services:

- 99441 - 99443
- 98966 - 98968
Telephone CPT Codes for Physician or other Health Care Professionals

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),

99442 (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; 11-20 minutes of medical discussion), and

99443 (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; 21-30 minutes of medical discussion).
Telephone CPT Codes for Qualified Nonphysician Health Care Professionals

CPT codes 98966 (Telephone assessment and management service provided by a qualified nonphysician 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 nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion),

98967 (Telephone assessment and management service provided by a qualified nonphysician 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 nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion),

98968 (Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and CMS-1744-IFC 123 management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion),
To facilitate billing of these services by therapists, we are designating CPT codes 98966-98968 as CTBS "sometimes therapy" services that would require the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services.
Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?

Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary. That doesn’t mean that service conducted via a video or through a window cannot be reported.
1. Do record the time started and time ended.
2. Do not record the session.
3. Ask for Consent to Treat verbally and document in Medical Record.
4. Do ask for vital signs.
5. Note the provider location and patient location.
RHCS WAITING ON

MEDICARE TELEHEALTH GUIDANCE
Thank you. Look for more Pop-up Webinars