Medicare Telemedicine

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- Information presented is done solely for informational and educational purposes

- Information should not be relied upon for purposes of regulatory compliance or as a guarantee for increased revenues or practice successes or failures

- Information provided herein does not constitute and should not substitute for legal advice; Practice should consult with Practice's own legal and regulatory counsel regarding all applicable legal and regulatory requirements

- All sample reports have blinded data, patient and provider identifiers have been given fictitious IDs and names

Format for Today's Webinar

- Telehealth Webinar held on 3/26/2020

https://globalmeetwebinar.webcasts.com/starthere.jsp?ei=1293854&tp_key=1686000a27

- Today's webinar will focus on recent updates (marked in red)
- Review COVID-19 related InfoDive Reports

Agenda

- Virtual Visits
  - Medicare Telehealth - UPDATED
  - Virtual Check-Ins - UPDATED
  - E-Visits - UPDATED

- Telephone Calls - UPDATED

- COVID-19 related InfoDive reports

Medicaid and Telemedicine

Varies State to State

- States have option/flexibility to determine whether (or not) to cover telemedicine
  - What types of telemedicine to cover
  - Where in state it can be covered
  - How it is provided/covered
  - What types of telemedicine practitioners/providers may be covered/reimbursed, as long as such practitioners/providers are "recognized" and qualified according to Medicaid statute/regulation
  - How much to reimburse for telemedicine services, as long as such payments do not exceed Federal Upper Limits
- If state decides to cover telemedicine, but does not cover certain practitioners/providers of telemedicine or its telemedicine coverage is limited to certain parts of state, then state is responsible for assuring access and covering face-to-face visits/examinations by these "recognized" practitioners/providers in those parts of state where telemedicine is not available

https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/covid19/index.html

Virtual Visits

Three Types:

1. Medicare Telehealth
2. Virtual Check-In
3. E-Visits

Medicare Telemedicine -

Fact Sheet and CMS Interim Final Rule

Visit Type	Service	HCPCs/CPT Codes	Patient Relationship with Provider
Medicare Telehealth Visits	Visit with provider that uses telecommunications systems between Provider and Patient	Common services: • 99201-99215 • G0425-G0427 • G0406-G0408 • Complete list link below	New or established patients
Virtual Check-In	Brief (5-10 minutes) check0in with provider via telephone or other telecommunication device to decide whether office visit or other service is needed. Remote evaluation of recorded video and/or images submitted by established patient.	G2010, G2012	Established patients
E-Visits	Communication between patient and provider through an online patient portal	99421, 99422, 99423 G2061, G2062, G2063	Established patients

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Medicare Advantage

- Medicare Advantage (MA) plans have flexibility to have more expansive telehealth policies related to types of services covered, where those services can take place (no geographic or site limitations), modality used
  - Still limits types of providers reimbursed
- CMS told MA Organizations they could expand coverage of telehealth services beyond what has already been approved by CMS
  - CMS will exercise its enforcement discretion until it is determined that it is no longer necessary in conjunction with COVID-19 outbreak
- Coverage is MA plan dependent
- MA plans do NOT have to provide more expansive telehealth services, they are only required to provide what is covered by Traditional Medicare

https://www.cms.gov/files/document/hpms-memo-covid-information-plans.pdf

Medicare Telemedicine

Things to Consider

- Communicate with patients
  - Place on website, social media, emails, patient portal, Facebook
  - Update phone message system, automated reminders, scheduling reminders
  - Post notice in all office locations
  - Call patients before in-office visit

Medicare Telemedicine

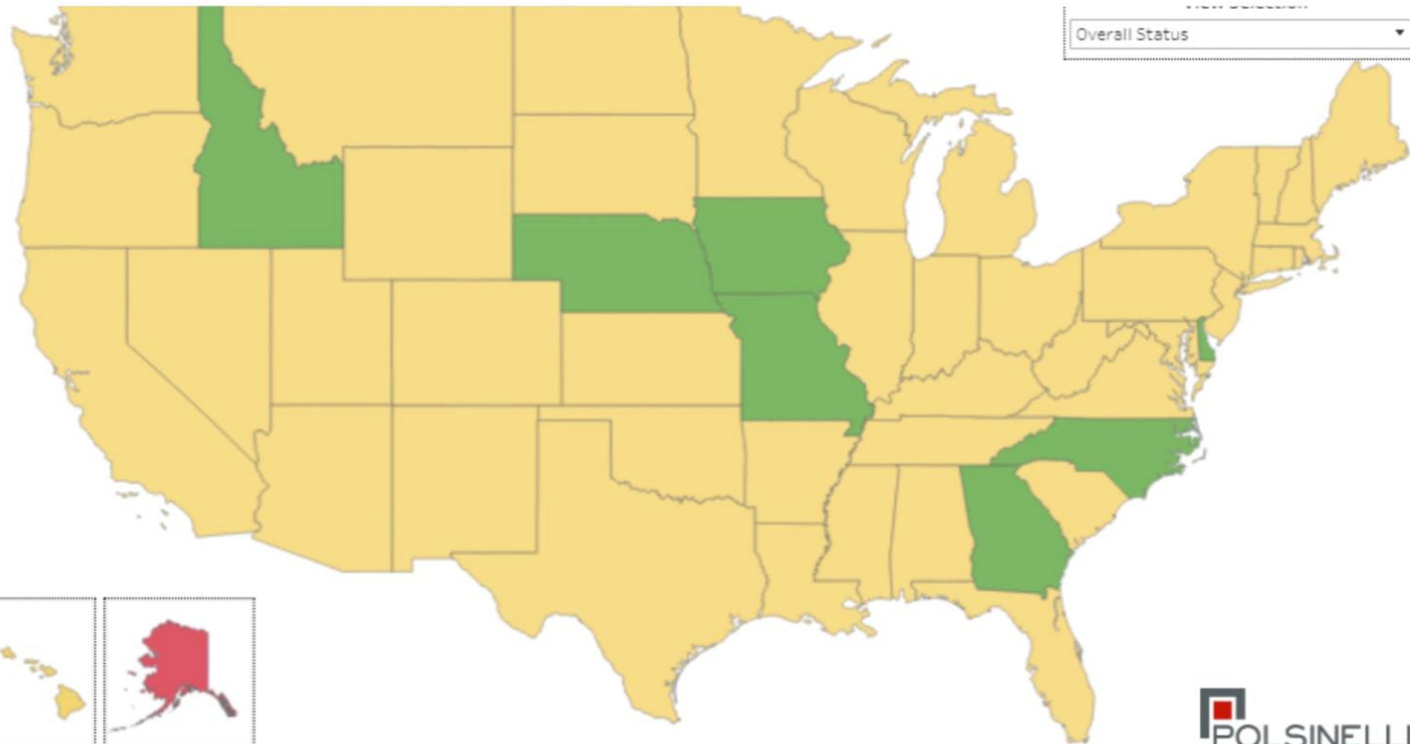
Things to Consider

- Malpractice Review
  - Be sure physician’s malpractice carrier allows for remote visits (to be safe, contact your malpractice carrier and ask)
    - According to what I have read, to date, there have been very few malpractice cases in telehealth (most in teleradiology)
      - However, no clear guidance regarding care provision during pandemic

- Practice located on State line
  - Practice licensed in multiple states?
    - During telehealth encounter, service is considered to take place at physical location of patient (as opposed to provider)
      - This requires providers to comply with laws and regulations associated with appropriate professional licensing board in patient's state
        - » In pandemic, practice legal resource may offer alternative guidance

COVID-19 Telemedicine Analysis by State - UPDATED

Analysis as of 3.27.2020



Yellow: Unclear. Emergency Orders and/or existing state law may facilitate out-of-state physician delivery of telemedicine services, but gaps and/or uncertainties in public record exist that do not permit a definitive conclusion. Consult counsel.

Red: No. Existing state law prohibits practice by physicians not licensed in state. Emergency orders or other guidance to facilitate telemedicine services are absent.

Green: Yes. Emergency orders and/or existing state law permits. Note: Out-of-state practitioners may still be required to comply with notice or other requirements in connection with the delivery of telemedicine services in the state. Consult state authority or counsel for guidance.

https://www.covid19.polsinelli.com/telehealth

Medicare Telemedicine

Things to Consider

- Talk with EHR Vendor
  - Does EHR have telemedicine platform?
  - Use existing scheduling system to book virtual visits
  - Create EHR template for telehealth visits

- Health Insurance Portability and Accountability Act (HIPAA)
  - Effective immediately, OCR will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency
  - Can use smart phone, tablet, laptop
    - FaceTime, Skype, Messenger video chat, Google hang out video, Doxy.me, Zoom for Healthcare, Updox
    - Can NOT use Facebook Live, Twitch, TikTok or other public facing communication services
  - Notify patient that third party platforms may have privacy risk

Medicare Telemedicine Visits

Waiver 1135 and CMS Interim Final Rule

- Medicare will pay for office, hospital, and other visits furnished via telehealth across country and including in patient's places of residence starting March 1, 2020 (Page 2, interim final rule)
  - Providers, physicians, nurse practitioners, clinical psychologists, and licensed clinical social workers can offer telehealth to patients
  - Medicare beneficiaries able to receive specific set of services through telehealth including regular office visits, mental health counseling and preventive health screenings
  - OIG providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs

- **Prior to waiver** Medicare would only pay for telehealth on limited basis:
  - When person receiving service was in designated rural area and when they leave their home and go to clinic, hospital, or certain other types of medical facilities for the service

Medicare Telemedicine Visits - UPDATED

Waiver 1135

- 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

Telehealth Visits

Requires two-way communication: video (via smart phone, laptop, computer, etc.) and phone

Medicare Telehealth Visits

For Duration of Public Health Emergency (PHE)

- Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances

- Visits are considered same as in-person visits and are paid at same rate as regular, in-person visits
  - Medicare will make payment for professional services furnished to beneficiaries in all areas of country in all settings, including patient's home

- Medicare coinsurance and deductible would generally apply to these services
  - **However**, OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs

- HHS will not conduct audits to ensure that prior relationship existed for claims submitted during this PHE

Medicare Telemedicine - UPDATED

Things to Consider

- Documentation requirements for Medicare Telehealth Visits and E-Visits are same as for face-to-face encounters
  - Information of visit, history, review of systems, consultative notes or any information used to make medical decision about patient should be documented
    - Documentation should include statement that service was provided through telehealth

- For Medicare Telehealth Visits, modifier is required if practice wants to bill for Place of Service (POS) 11 (vary based on service provider)
  - Interim Final Rule
    - Instructed physicians and practitioners who bill for Medicare telehealth services to report POS code that would have been reported had service been furnished in person
    - GQ and GT Modifiers: No longer required except in Alaska and Hawaii – see below, use POS 02
      - In cases when telehealth service is furnished via asynchronous (store and forward) technology as part of federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required
  - Modifier 95: Used when billing Medicare Telehealth at POS 11
    - Some private payers may also require – check with your commercial payers –Medicaid may or may NOT recognize modifier 95
  - Place of Service 02 still applies: Defined as "the location where health services and health-related services are provided or received, through a telecommunication system"

Medicare Telehealth Visits - UPDATED

List of CPT Codes 2020

- 191 CPT Codes (added 90 additional codes)
- Obtain patient consent – only need annual consent
  - Can be obtained by office staff
  - Verbal consent is acceptable
  - Document consent in note
- Document visit as you would in-office visit
- UPDATED: *Previously,* payment for telehealth services was tied to (typically lower) facility rate
  - To receive payment at same rate as in-person office visits, use same place of service (POS) code that would have been reported had service been furnished in person
  - CPT telehealth modifier (modifier 95) must be used to indicate service was furnished via telehealth
  - Do not use 02 POS unless practice wants to receive lower facility rate

See attachments titled: 508 Compliant Version of List of Medicare Telehealth Svc – 20200330 - Excel
Sample Telemedicine Patient Consent Form

2020 Medicare Physician Fee Schedule - UPDATED

Status Column

LIST OF MEDICARE TELEHEALTH SERVICES CPT Codes	Short Descriptor	Status
97802	Medical nutrition indiv in	
97803	Med nutrition indiv subseq	
97804	Medical nutrition group	
99201	Office/outpatient visit new	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic

Updated

CMS 1500:

- Box 24B
  - POS is 02 for Telehealth
  - POS is 11 if Telehealth done in office
  - POS is 11 for Virtual Check-In and E-Visits
- BOX 24D:
  - Modifier 95 for Medicare Telehealth
- Box 32
  - Service Facility Location Information
  - Provider should enter address where they typically practice
  - If provider furnishes some or all of these services from their home or another location that is not their typical practice location, they should use the address of office location where they usually practice

HEALTH INSURANCE CLAIM FORM

See attached letter titled: CMS Telehealth Compilation Final Dec 2019 CMS 1500 Box 32

See attached Interim Final Rule titled: CMS 1744 IFC

Virtual Check-In

Virtual Check-Ins - UPDATED

For Duration of Public Health Emergency (PHE)

- Not considered Telehealth
- Can be billed for new and established patients - exercising enforcement discretion
  - Not limited to rural settings or certain locations
- Individual services need to be agreed to by patient (consent can be obtained by office staff); however, providers may educate beneficiaries on availability of service prior to patient agreement
- Two CPT Codes
  - G2012 – MPFS – National $14.80
  - G2010 – MPFS – National $12.27
- Can be conducted with broader range of communication methods (including telephone), unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication

Virtual Check-Ins

For Duration of Public Health Emergency (PHE)

- G2012 (Brief communication technology-based virtual check-in)
  - Use when check-in does not result from service within past 7 days, or result in service in next 24 hours, or next available appointment
  - Brief, non-face-to-face service provided by a physician or non-physician practitioner, not a staff member
    - Can be billed by occupational therapist, physical therapist, and speech-language pathologist to include corresponding GO, GP, or GN therapy modifier on claims for these services
  - New or established patients - exercising enforcement discretion
  - Social workers and other types of therapists may not use it
  - Use to determine if appointment is needed

- Requires patient verbal consent to bill and is subject to co-insurance and deductible

Virtual Check-Ins

For Duration of Public Health Emergency (PHE)

- G2010 (Store and forward)
  - Provider can use this code to review picture or video
  - Use when check-in does not result from service within past 7 days, or result in service in next 24 hours, or next available appointment
  - New and established patients - exercising enforcement discretion
  - Provider looks at image or video, and there is subsequent communication by the provider or staff member to patient
    - Follow up is required within 24 hours
    - If image is insufficient to make determination, it can't be billed
  - Requires patient verbal consent (can be obtained by office staff) to bill and is subject to co-insurance and deductible

E-Visits

E-Visits - UPDATED

For Duration of Public Health Emergency (PHE)

- Services can be reported for new and established patients -exercising enforcement discretion

- Not limited to rural settings
  - No geographic or location restrictions

- Verbal patient consent required annually (consent can be obtained by office staff)
  - Patients communicate with their physicians without going to office by using online patient portals

- Individual services need to be initiated by patient; however, practitioners may educate beneficiaries on the availability of service prior to patient initiation

- Services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable

- Medicare coinsurance and deductible would generally apply to services

E-Visits

For Duration of Public Health Emergency (PHE)

- 2020 - Three new CPT codes for physicians, physician assistants and advanced practice nurse practitioners performing brief, online EM services via secure platform
  - 99421 Online digital EM service, for established patient, for up to 7 days cumulative time during 7 days; 5-10 minutes – MPFS – National $15.52
  - 99422 11—20 minutes – MPFS – National $31.04
  - 99423 21 or more minutes – MPFS – National $50.17
- Use when EM services are performed, of type that would be done face-to-face, through HIPAA compliant secure platform
- Patient-initiated communications, and billed by clinicians who independently bill EM service
  - They may not be used for work done by clinical staff or for clinicians who do not have EM services in scope of practice

E-Visits - UPDATED

For Duration of Public Health Emergency (PHE)

- 2020 - Three new CPT codes for online services provided by clinicians who may not bill EM services
  - Example: speech-language pathologists, physical therapists, occupational therapists, social workers, dietitians
    - Include corresponding GO, GP, or GN therapy modifier on claims for these services
  - Instead of "evaluation and management" CPT definitions use word "assessment"
    - G2061 (Online assessment, for established patient, for up to 7 days, cumulative time during 7 days) 5-10 minutes – MPFS – National $12.27
    - G2062 11-20 minutes – MPFS – National $21.65
    - G2063 21 or more minutes – MPFS – National $33.92

E-Visits

For Duration of Public Health Emergency (PHE)

- Report these services once during 7 day period, for cumulative time

- To count time for these codes, start 7 day clock when physician or qualified health care professional (QHP) first performs personal review of patient's question
  - Add in time for review of relevant patient records and data, interaction with clinical staff regarding patient's problem, developing management plans (including prescriptions and test orders), and further communication with patient by digital means that doesn't fall under another EM code
  - Includes decision-making, assessment and management by those in same group practice, too, but can't count clinical staff time

- When NOT to bill for these online services
  - **Online followed by other EM**: If patient initiates online EM service and then presents for a separately reported EM within seven days, include online EM work in separately reported EM
  - **EM followed by online service**: If patient presents for EM and then initiates online inquiry for same problem or related one within 7 days, don't report online service
  - **Online EM during post-op period**: Don't separately report online inquiries related to surgery during postop period

Telephone Services

Telephone Services - UPDATED

Covered by Medicare and Some Commercial Payers

- Non face-to-face services using telephone
  - Code descriptors include language that recognizes provision of services to parties other than beneficiary for whom Medicare does not provide coverage (for example, a guardian)
  - Codes can be reported for new and established patients (exercising enforcement discretion) and are not billable if call results in patient coming in for face-to-face service within next 24 hours (or next available urgent visit appointment)
  - These calls are also not billable if they refer to EM service performed within last seven days

- Telephone Services
  - Physician
    - 99441: 5- 10 minutes of medical discussion
    - 99442: 11-20 minutes of medical discussion
    - 99443: 21-30 minutes of medical discussion
  - Advanced Practice Providers (APP)
    - 98966: 5- 10 minutes of medical discussion
    - 98967: 11-20 minutes of medical discussion
    - 98968: 21-30 minutes of medical discussion

Telephone Services - UPDATED

Covered by Medicare and Some Commercial Payers

- Patient or patient's parent/guardian must initiate contact as these codes may not be used for calls initiated by provider
- Codes are used only for services personally performed by physician
- CMS designated all telephone evaluation management codes with status indicator "N" which indicates service not covered by CMS
  - Waived during PHE
- RVUs are listed in MPFS
  - Some commercial payers may cover these services and use RVUs assigned by Medicare to set payment rates

HCPCS	MOD	DESCRIPTION	STATUS CODE	NOT USED FOR MEDICARE PAYMENT	WORK RVU	NON-FAC PE RVU	MP RVU	NON-FACILITY TOTAL
99441		Phone e/m phys/qhp 5-10 min	N	+	0.25	0.13	0.02	0.40
99442		Phone e/m phys/qhp 11-20 min	N	+	0.50	0.23	0.05	0.78
99443		Phone e/m phys/qhp 21-30 min	N	+	0.75	0.33	0.06	1.14

Telephone Services - UPDATED

Covered by Medicare and Some Commercial Payers

- Patient or patient's parent/guardian must initiate contact as these codes may not be used for calls initiated by provider
- Codes are used only for services personally performed by APP
- CMS designated all telephone evaluation management codes with status indicator "N" which indicates service not covered by CMS
  - Waived during PHE
- RVUs are listed in MPFS
  - Some commercial payers may cover these services and use RVUs assigned by Medicare to set payment rates

HCPCS	MOD	DESCRIPTION	STATUS CODE	NOT USED FOR MEDICARE PAYMENT	WORK RVU	NON-FAC PE RVU	NON-FAC NA INDICATOR	FACILITY PE RVU	FACILITY NA INDICATOR	MP RVU	NON-FACILITY TOTAL
98966		Hc pro phone call 5-10 min	N	+	0.25	0.13		0.10		0.02	0.40
98967		Hc pro phone call 11-20 min	N	+	0.50	0.23		0.19		0.05	0.78
98968		Hc pro phone call 21-30 min	N	+	0.75	0.33		0.29		0.06	1.14

Telephone Services - UPDATED

Covered by Medicare and Some Commercial Payers

- Documentation Requirements:
  - Telephone Visit should be documented in medical record
  - Minimum required documentation elements include:
    - Notation patient consented to contact via telephone
    - Names of all people present during telephone call and their role
    - Chief complaint or reason for telephone visit
    - Relevant history, background, and/or results
    - Assessment
    - Plan and next steps
    - Total time spent on medical discussion

- Does NOT qualify as Telephone Visit
  - Appointment reminder
  - Communication of normal routine results or other information that can be communicated by non-licensed staff

Interprofessional Consultations (Added Section)

Not Telemedicine

CMS does **not consider** an eConsult to be "telehealth" service, but rather part of what it calls "Special Care Management" codes

Interprofessional Consults

- CMS recognized 6 codes for interprofessional consults in 2019
  - 4 were existing codes that had status indicator of bundled which changed to active status, indicating payment by Medicare
  - By unbundling these codes, need for specialist appointment was removed, and now codes 99446-99449 can be billed for as non-face to face communication
- 2 were new CPT codes, also with active status indicator
- All time-based codes

Interprofessional Consult CPT Codes

- These 6 codes describe assessment and management consultative service provided by phone, internet or EHR when patient's treating physician/ non-physician practitioner (NPP) requests an opinion and/or treatment advice of consulting physician

CPT Code	Reported by	Must Include	Time	Services Provided
99446	Physician Consultant	Verbal and Written Report to requester	5-10 minutes	Review pertinent medical records, lab/imaging studies, medication record, etc. and medical consultative verbal or internet discussion
99447	Physician Consultant	Verbal and Written Report to requester	11-20 minutes	Review pertinent medical records, lab/imaging studies, medication record, etc. and medical consultative verbal or internet discussion
99448	Physician Consultant	Verbal and Written Report to requester	21-30	Review pertinent medical records, lab/imaging studies, medication record, etc. and medical consultative verbal or internet discussion
99449	Physician Consultant	Verbal and Written Report to requester	≥ 31 minutes	Review pertinent medical records, lab/imaging studies, medication record, etc. and medical consultative verbal or internet discussion
99451	Physician Consultant	Written Report to treating/requesting physician/QHP	≥ 5 minutes	Review pertinent medical records, lab/imaging studies, medication record, etc. and medical consultative verbal or internet discussion
99452	Treating/Requesting Physician or QHP	NA	≥ 16 minutes	Preparing for the consult and/or the actual time spent communicating with the consulting physician

Interprofessional Consults

CPT Rules for Reporting by Consulting Physician

- Definition specifically says consulting physician, not "or other qualified health care professional"
- Do not bill for services performed by nurse practitioner or physician assistant
- Treating physician/NP/PA requests opinion and/or treatment advice of physician with specific specialty expertise to assist in diagnosis or management of patient's problem without seeing patient
- May be new or established patient to consultant, for new or existing problem
- *Consultant may not have had face-to-face service with patient in last 14 days*
- *May not bill if review leads to face-to-face service with patient in next 14 days*
- Majority of time must be medical consultative verbal or internet discussion (greater than 50%)
- For 99446, 99447, 99448, 99449, if greater than 50% is in data review and/or analysis, do not bill those codes; according to CPT, this doesn't qualify
- 99451 may be billed if more than 50% of 5-minute time is data review and/or analysis
- Do not report these codes more than once in 7-day period
- Do not use for transfer of care
- Written or verbal request should be documented in patient's medical record, including reason for consult
- Codes are payable in both facility and non-facility setting

Interprofessional Consults

CPT Rules for Reporting Interprofessional Consultations by Treating Physician or other QHP

- CPT code 99452
  - May be requested and billed by physician, NP, PA
  - Use for time of 16-30 minutes in service day preparing for referral and/or communicating with consultant
  - May not be billed more than once in 14-day period
  - May report face-to-face prolonged care codes with this service if EM service is also provided and time exceeds 30 minutes beyond typical time
  - If patient is not present, may report non-face-to-face prolonged codes if time spent in day exceeds 30 minutes

Medicare Telemedicine (Provided Webinar on 3-26-2020)

Attachments

- Medicare Telemedicine Healthcare Provider Fact Sheet
- Telemedicine Patient Consent Form
- Medicare FAQ on Telehealth Waivers
- Enforcement Discretion for Telehealth Remote Communications during COVID-19
- Medicare Telemedicine CPT Code List (2019 and 2020)
- General Telehealth Toolkit
- CMS Telehealth MLN March 2020
- CMS Telehealth Compilation Final Dec 2019 CMS 1500 Box 32

Medicare Telemedicine Additions

Attachments

- 508 Compliant Version of List of Medicare Telehealth Svc – 20200330 – Excel
- CMS COVID-19 Fact Sheet (03302020)
- CMS 1744 IFC (03-30-2020)

Resources - UPDATED

- AHIP (America's Health Insurance Plans) published list regarding COVID-19 (testing, telehealth, etc.), on an insurance by insurance basis
  - https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/

AHIP

ISSUES RESEARCH NEWS EDUCATION EVENTS ABOUT US MEMBER LOGIN

Health Insurance Providers Respond to Coronavirus (COVID-19)

BLOG

The health and well-being of millions of Americans remains our highest priority. Health insurance providers are committed to help prevent the spread of the coronavirus strain COVID-19. We are activating emergency plans to ensure that Americans have access to the prevention, testing, and treatment needed to handle the current situation.

While most reported cases of COVID-19 are in other countries, the number of cases in the United States continues to increase. Here are some ways health insurance providers are taking action:

- **Aetna** will waive co-pays for all diagnostic testing related to COVID-19, according to **CVS Health**. That includes all member costs associated with diagnostic testing for Commercial, Medicare, and Medicaid lines of business. Self-insured plan sponsors will be able to opt-out of the program at their

posted by AHIP
on April 2, 2020

Click Here to Learn More

Thank You.

Q & A

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reach and partnership
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