

Virtual Care Reimbursement Update and Frequently Asked Questions

Tuesday, July 26, 2022 | 1:00 PM ET



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Virtual Care Reimbursement

Agenda

- Medicare Telehealth Coverage
 - Pre PHE
 - Current Coverage
 - Post PHE Considerations
- Medicare Enrollment and Claims Processing Considerations
- Medicaid Telehealth Coverage

Virtual Care Reimbursement

Medicare Telehealth Coverage

- Defined by Statute
 - Social Security Act 1834(m)(4) Definitions
 - A) Distant site: The term "distant site" means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.
 - (B) Eligible telehealth individual: The term "eligible telehealth individual" means an individual enrolled under this part who receives a telehealth service furnished at an originating site.
 - (C) Originating site: Location of the Medicare beneficiary, includes Physician/Practitioner Office, CAH, RHC, FQHC, hospital, hospital/CAH-based renal dialysis center, SNF, CMHC, renal dialysis facility (limited), home of an individual (limited)
 - (D) Physician: The term "physician" has the meaning given that term in section 1861(r).
 - (E) Practitioner: The term "practitioner" has the meaning given that term in section 1842(b)(18)(C).
 - (F) Telehealth service: (i) In general.—
 - The term "telehealth service" means **professional** consultations, office visits, and office psychiatry services (identified as of July 1, 2000, by HCPCS codes 99241-99275, 99201-99215, 90804-90809, and 90862 (and as subsequently modified by the Secretary)), and any additional service specified by the Secretary.

Telehealth Coverage

Medicare Coverage Prior to Public Health Emergency

- Limited: defined terms within SSA
 - Geographic restriction for location of the patient (“originating site”)
 - Generally required a rural geographic location
 - Pro fee was only covered if patient was located at one of the originating sites listed in Section 1834(m) of the SSA and only by certain practitioners
 - “Distant site” (location of the practitioner) not restricted but for FQHCs/RHCs
 - Defined set of “telehealth” services in the SSA and as updated by the Secretary of HHS
 - Generally required HIPAA-compliant two-way audio/visual communication

Telehealth Coverage

Medicare Coverage Prior to Public Health Emergency

- Regulation: 42 CFR 410.78
 - Distant Site Practitioners
 - Physician
 - Physician Assistant
 - Nurse Practitioner
 - Clinical Nurse Specialist
 - Nurse Mid-Wife
 - Clinical Psychologist
 - Clinical Social Worker
 - Registered Dietitian or Nutritional Professional
 - Certified Registered Nurse Anesthetist

Telehealth Coverage

Medicare Coverage During the Public Health Emergency

- March 17, 2020, CMS Fact Sheet <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: <ul style="list-style-type: none"> • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *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
VIRTUAL CHECK-IN	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.	<ul style="list-style-type: none"> • HCPCS code G2012 • HCPCS code G2010 	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	<ul style="list-style-type: none"> • 99421 • 99422 • 99423 • G2061 • G2062 • G2063 	For established patients.

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Telehealth Coverage

Medicare Coverage During the Public Health Emergency

- Authority: §1135 waivers, CARES Act, IFRs
- Geographic restrictions removed
 - Patient can be located at an originating site anywhere in the U.S., including in the home; distant-site practitioner pro fees can be covered regardless of geographic location of the patient
 - Payment rule established for RHCs and FQHCs as the location of the distant site practitioner
- Patient can be a new or established patient
- All practitioners authorized to bill Medicare for professional services can furnish and bill for telehealth services
 - For example, PTs and OTs but not pharmacists
- Generally, requires audio/visual, two-way real-time communication
 - Telephone E/M codes and certain counseling (behavioral) and educational services can be furnished audio-only
- List of covered services: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>
- FFS Billing FAQs: <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>

Telehealth Coverage

Medicare Coverage During the Public Health Emergency

- Category 3 services (temp services added during PHE) retained through end of CY 2023
- Use of virtual technologies to meet conditions of payment
 - Permits physicians to supervise clinical staff using virtual technologies, when appropriate, instead of requiring in-person presence (“incident to” services)
 - Amended definition of “direct supervision” at 42 CFR 410.32 to permit virtual presence through real-time audio/visual communication during duration of PHE (diagnostics)
- Other “virtual services” also covered (ex. RPM, RTM)
- Permanent telehealth changes to geographic location, eligible providers and originating sites require statutory changes

Telehealth Coverage

CY 2022

- Mental telehealth services covered without geographic restrictions but includes in-person visit requirements
- Definition of “home” includes temporary lodging such as hotels and homeless shelters and when beneficiary chooses to travel “a short distance from the exact home location”
- End of virtual supervision policy for direct supervision
- CMS ending coverage for audio-only E/M services (CPT codes 99441-99443) at end of PHE
- CCA of 2022 extends telehealth flexibilities 151 days following end of the PHE (currently extended through October 13, 2022)

Telehealth Coverage

CY 2023 – Proposals from MPFS

- Reiterates coverage of Category 3 telehealth codes through end of CY 2023
- Temp services on telehealth list that are not identified as Category 1-3 codes covered for 151 days following end of PHE in alignment with CCA of 2022
- CMS proposes to implement CCA of 2022 telehealth provisions through program instruction or other sub-regulatory guidance
 - Current flexibilities for originating site and eligible distant site practitioners extended 151 days following end of PHE
- Claims will require appropriate POS code (rather than modifier 95) after 151 days following end of PHE; modifier 93 for “audio only” when appropriate

Telehealth Coverage

Payment Considerations for the Future

- Senate Finance Committee Hearing; May 2021 Telehealth Expansion
- HFMA article quotes health care policy expert: “FFS is a particularly inappropriate payment method for most telehealth services”
 - Administrative complexity
 - Billing costs in relation to payment levels
 - Increased volume and spending
- Capitated payment models for telehealth is essential both to manage overall spending and to promote innovation; FFS could be interim strategy
- Pending legislation would permanently incorporate some of the telehealth waivers that were established in response to the PHE

Enrollment and Reassignment

After the PHE: Manual Guidance

- *Medicare Claims Processing Manual* requires claims for telehealth services to be processed by the MAC for the “performing physician’s service area.”
Chapter 12:

190.6.1 - Submission of Telehealth Claims for Distant Site Practitioners (Rev. 3817; Issued; 07-28-17 Effective; 01-01-18 Implementation: 01-02-18)

“Claims for telehealth services are submitted to the contractors that process claims for the performing physician/practitioner’s service area. Physicians/practitioners submit the appropriate HCPCS procedure code for covered professional telehealth services with place of service code 02 (Telehealth). By billing place of service code 02 with a covered telehealth procedure code, the distant site physician/practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished.”

Enrollment and Reassignment

After the PHE: CMS Manual Guidance

- *Medicare Program Integrity Manual*, Chapter 10, Section 10.3.1.4.3 “Inter-jurisdictional Reassignments”
- Requires the Group Practice (reassignee) to enroll in the MAC jurisdiction where the reassignor (physician/NPP) is located
- General policy:
 - If a physician/NPP (reassignor) is reassigning his or her benefits to an entity (reassignee) located in another contractor jurisdiction – a practice that is permissible - the following principles apply:

Enrollment and Reassignment

After the PHE: CMS Manual Guidance

1. The reassignor [MD/NPP] must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location. The practice location can be an office or even the individual's home (*for example, a physician interprets test results in his home for an independent diagnostic testing facility*).
*Emphasis Added
2. The reassignor [MD/NPP] need not – pursuant to the reassignment - enroll in the reassignee's [Group] contractor jurisdiction nor be licensed/authorized to practice in the reassignee's [Group] state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the Medicare contractor for – and be licensed/authorized to practice in – that state.

Enrollment and Reassignment

After the PHE: CMS Manual Guidance

3. The reassignee [Group] must enroll in the contractor jurisdictions in which (1) it has its own practice location(s), and (2) the reassignor [MD/NPP] has his or her practice location(s). In Case (2), the reassignee:
 - Shall identify the reassignor's practice location as its practice location on its Form CMS-855B
 - In Section 4A of its Form CMS-855B shall select the practice location type as "Other health care facility" and specify "Telemedicine location."
 - Need not be licensed/authorized to perform services in the reassignor's state.

Enrollment and Reassignment

After the PHE: CMS Manual Guidance

Example in the *Manual* Guidance:

To illustrate, suppose Dr. Smith is located in Contractor Jurisdiction X and is reassigning his benefits to Jones Medical Group in Contractor Jurisdiction Y. Jones [Medical Group] must enroll with X and with Y. Jones [Medical Group] need not be licensed/authorized to perform services in Dr. Smith's state. However, in Section 4 of the Form CMS- 855B it submits to X, Jones [Medical Group] must list Dr. Smith's location as its practice location.

Enrollment and Reassignment

After the PHE: CMS Manual Guidance

What if Dr. Smith is telehealth only?

- Dr. Smith is only seeing patients located in Contractor Jurisdiction Y (location of Jones Medical Group)
- Dr. Smith likely needs to be licensed in the Contractor Y Jurisdiction (the State where the patients are located)
- But since Dr. Smith is physically located in Contractor Jurisdiction X, Dr. Smith/Jones Medical Group has to enroll in X and Dr. Smith needs to be licensed in X's State for purposes of enrollment
- ***“The reassignor must be properly licensed or otherwise authorized to perform services in the state in which he or she has his or her practice location.”***

Claims Processing

Payment Jurisdiction

- *Medicare Claims Processing Manual*, Chapter 12, Section 190.6 **“Payment Methodology for Physician/Practitioner at the Distant Site”**
- “Distant Site” = “Where the [MD/NPP], providing the professional service, is located at the time the service is provided via a telecommunications systems.”
- “Payment Amount (Pro Fee)” = “. . . is equal to the current fee schedule amount for the services provided at the facility rate.”
- “As a condition of Medicare Part B payment for telehealth services, the physician or practitioner at the distant site must be licensed to provide the service under state law.”

Claims Processing

Payment Jurisdiction

- Why does the location matter? Payment locality (by zip code) determines appropriate payment. *Medicare Claims Processing Manual*, Chapter 1:
10.1.1 - Payment Jurisdiction among A/B MACs (Part B) for Services Paid Under the Physician Fee Schedule and Anesthesia Services (Rev. 4473, Issued: 12-6-19; Effective: 3-9-20; Implementation: 3-9-20)
“The jurisdiction for processing a request for payment for services paid under the Medicare Physician Fee Schedule (MPFS) and for anesthesia services is governed by the payment locality where the service is furnished and will be based on the ZIP code.”
“Effective for claims received on or after April 1, 2004, A/B MACs (Part B) must use the ZIP code of the location where the service was rendered to determine A/B MACs (Part B) jurisdiction over the claim and the correct payment locality.”

Medicaid and Telehealth

- **Rule of Thumb**: Do not assume your state's Medicaid program will cover a telehealth service reimbursable under Medicare
- Every state is different, and policies are changing frequently
- Public Health Emergency Waivers
 - Many state Public Health Emergency declarations for COVID-19 included waivers to allow for Medicaid coverage of telehealth where that coverage did not previously exist.
 - Some states have relaxed the state Public Health Emergency, but some are still in effect.
- Medicaid Managed Care Organizations
 - By law, the Medicaid Managed Care Organizations can adopt slightly different payment policies and may cover telehealth where the Fee-For-Service Medicaid does not

Medicaid and Telehealth

Where do I look for Medicaid Telehealth guidance?

- Statutes
- Regulations
- Public Health Emergency Declarations, which could come from the Governor's office, not the Medicaid agency
- Manuals
- Bulletins
- Medicaid Agency emails

Medicaid and Telehealth

Medicaid Trends in Telehealth

- Patient's home or location can be the originating site
- Audio only
- Asynchronous, aka "store and forward"
- Behavioral Health coverage is increasing under Medicaid and includes telehealth coverage
- Teledentistry has started appearing

Medicaid and Telehealth

Be careful!

- Check whether the telehealth reimbursement is permanent; some states have implemented an expiration dates.
- Medicaid telehealth reimbursable services rarely include facsimile, email, or text communications
- Sometimes you need an established patient relationship
- Watch your modifiers! (They are often different from Medicare.)
- Double check claims forms... Medicaid post payment audit activity is increasing

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Questions?

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