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E-Reimbursement Newsletter

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As you may know, yesterday, we put a newsletter outlining the CMS Summaries and Press Release for the extension of Waivers for COVID-19. As we mentioned in that newsletter, there were several areas where we needed clarification. We reviewed the Interim Final Rule (CMS-1744-ifc) and found some clarification on things we were wondering about.

Here is an update. **PAY PARTICULAR ATTENTION to the changes in billing of services**. All page numbers are from the Interim Final Rule.

BILLING CLARIFICATION FOR COVID-19

On March 30, CMS released an Interim Final Rule (CMS-1744-ifc) with clarification of many items we reviewed in our newsletter yesterday. It also highlights many of the issues that we have had with telehealth since regulations for telehealth changed last month. In no particular order, here is summary of what we found in the Interim Final Rule as changes for FFS Medicare patients:

Use of Telephones for Telehealth
We have seen reports that you can use a telephone for Medicare telehealth. In order t**o bill office visits or any of the 190 services now authorized for telehealth, the billing provider must have interactive, real-time audio visual with the patient**. It can be a variety of media including Smartphones but the VISUAL aspect is still required for telehealth encounters. This week, **Medicare authorized telephone calls for telephone only encounters.** (Page 48)

New 1135 Waiver Billing for Telehealth Services
For "traditional" telehealth per Medicare Rules prior to COVID-19 (Patient in facility; rural area, not at home), continue to use Place of Service 02.

But, effective March 1, 2020. CMS has revised the place of service billing for telehealth claims. Do not use POS 02 for CMS telehealth claims under the Waiver, **use the place of service that would have been used if the patient had been seen face-to-face. So, if you would have seen the patient in the office, use POS 11 on the claim along with MODIFIER -95 (Pages 13-15)**

In terms of payment, if there is a facility and a non-facility fee schedule amount, like with office visits (99201-99215), if your POS is 11, you will be paid the higher, non-facility rate, not the facility rate. This is a positive difference for office visits billed with POS 11, not so much for hospital outpatient. Again, CMS now requires Modifier -95 on the claim.

Online digital E/M (99421, 99422 and G2061, G2062), **phone calls (99441, 99442, 98966, 98968), virtual**

Online digital E/M (99421–99423 and G2061–G2063), **phone calls (99441–99443, 98966–96968), virtual check in (G2010, G2012) and remote monitoring are not considered telehealth services. Do not use POS 02 or modifier 95 with these. This may not be true for your private payers.**

E/M Criteria for Office Visits

As a sneaky peek at 2021 E/M coding, CMS is changing the criteria for office visits. As we have reviewed herein, in 2021, CMS is changing the selection of E/M Services to **either time or Medical Decision-Making ("MDM")**. As per this rule, CMS is allowing on an interim basis to apply 2021 selection rules to office/outpatient visits performed via telehealth during the time of COVID-19. As a result, **they are temporarily deleting any requirement for history and/or physical exam**. **Providers who perform E/M services can use MDM or time to select the code, with time defined as "all of the time associated with the E/M on the day of the encounter." The time and/or level of MDM used will be selected from the 2020 E/M service descriptors rather than the projected 2021 criteria. So, to reiterate,** 99201–99215 provided via telehealth (real time, interactive audio/visual) a practitioner does not need to use the level of history or exam to select the service. If time is your criteria, document total time that the practitioner (not staff) spends on that day, even if counseling dominates the visit. But, with counseling, you also need counseling time representing 50% of the visit. (Pages 135-136)

Direct Supervision

As many of you know, **the Part B "incident to" rules require direct supervision, meaning the physician must be in the office suite and available during all chemos and drug administration. Same with 'incident to' NPP E/M. CMS attempts to define direct supervision when the doctor is not present. Here is what they say: "***On an interim basis for the duration of the PHE for the COVID-19 pandemic, we are altering the definition of direct supervision at § 410.32(b)(3)(ii), to state that necessary presence of the physician for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We are revising § 410.32(b)(3)(ii) to include, during a PHE, as defined in § 400.200 of this chapter, the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider."* **My question is: does that mean they are available using audio-visual technology or have to be online throughout? In one part of the Interim Rule, CMS states "when needed" or "appropriate supervision". So, my guess is that it can be when needed, but further clarification would be helpful. In either case, it might be wise to ensure that the availability of the physician through 2-way communication is documented for each encounter. (Pages 55-58)**

Lifting of Established Patient Requirements

As you know. CMS lifted the requirement that telehealth services when they initially changed the rule. In this Interim Final Rule, CMS lifts Established Patient Criteria for Brief Check-ins G2010-G2012 (Page 52), E-visits 99421-99423; G2061-G2063 (Will not audit, Page 53), and for the newly approved telephone calls 99441-99443, 98966-98968 (Page 125).

For a complete version of the Interim Final Rule, click here.