A GLIMPSE OF TELEHEALTH REIMBURSEMENT: NOW AND POST-PUBLIC HEALTH EMERGENCY

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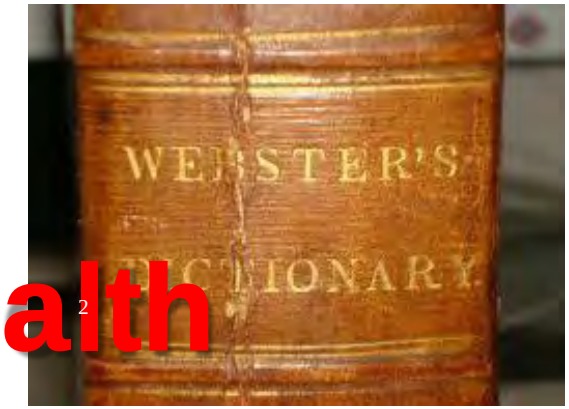
10th Annual Telehealth Summit, Charleston SC
November 9-10, 2022

telehealth [tel´ĕ-helth]

The use of electronic information and telecommunications technologies to support long-distance clinical health care, professional health-related education, public health, and health administration.

When the sender and receiver are not in the same physical location.



Definition of TeleHealth

Telemedicine or Telehealth - Definitions

Telemedicine or Telehealth

There are many definitions of telemedicine and telehealth. Sometimes the terms are used interchangeably, and often there is confusion about what is included. As the field is growing with many new apps and services, telemedicine/telehealth is constantly evolving and an absolute definition of these terms remains elusive.

Federal/National/International Definitions:

The Health Resources Services Administration (HRSA) "defines telehealth as the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

Telehealth is different from telemedicine because it refers to a *broader scope of remote healthcare services* than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-direct patient care services, such as provider training, administrative meetings, and continuing medical education, in addition to clinical services."

For purposes of Centers for Medicare and Medicaid Services (CMS), "telemedicine seeks to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment".

World Health Organization (WHO) "The delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities"

American Telemedicine Association (ATA) "telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status. Telemedicine includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology".

Federation of State Medical Boards (FSMB) "Telemedicine means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient."

The American Medical Association (AMA) has declined to offer a specific definition of telemedicine stating, "The definition of telemedicine, as well as telehealth, has continued to evolve, and there is no consensus on the definition of either of the two terms."

TeleHealth is a tool for improving access and attaining quality metrics that influence and change population health care beliefs and behaviors.

Getting Paid for Services Delivered Via TeleHealth

- Patient – Provider Relationship
- Requirements for TelePresenters
- Need for Informed Consent
- Licensure Requirements
- Parity Law
- Controlled Substance Prescribing
- Internet Prescribing
- Medical Board Rules on Telemedicine

PAYER'S DEFINITION OF TELEHEALTH

Practice

Medical and other Practice Boards
Office of Insurance Commissioner
Consumer Protection
Security and Privacy

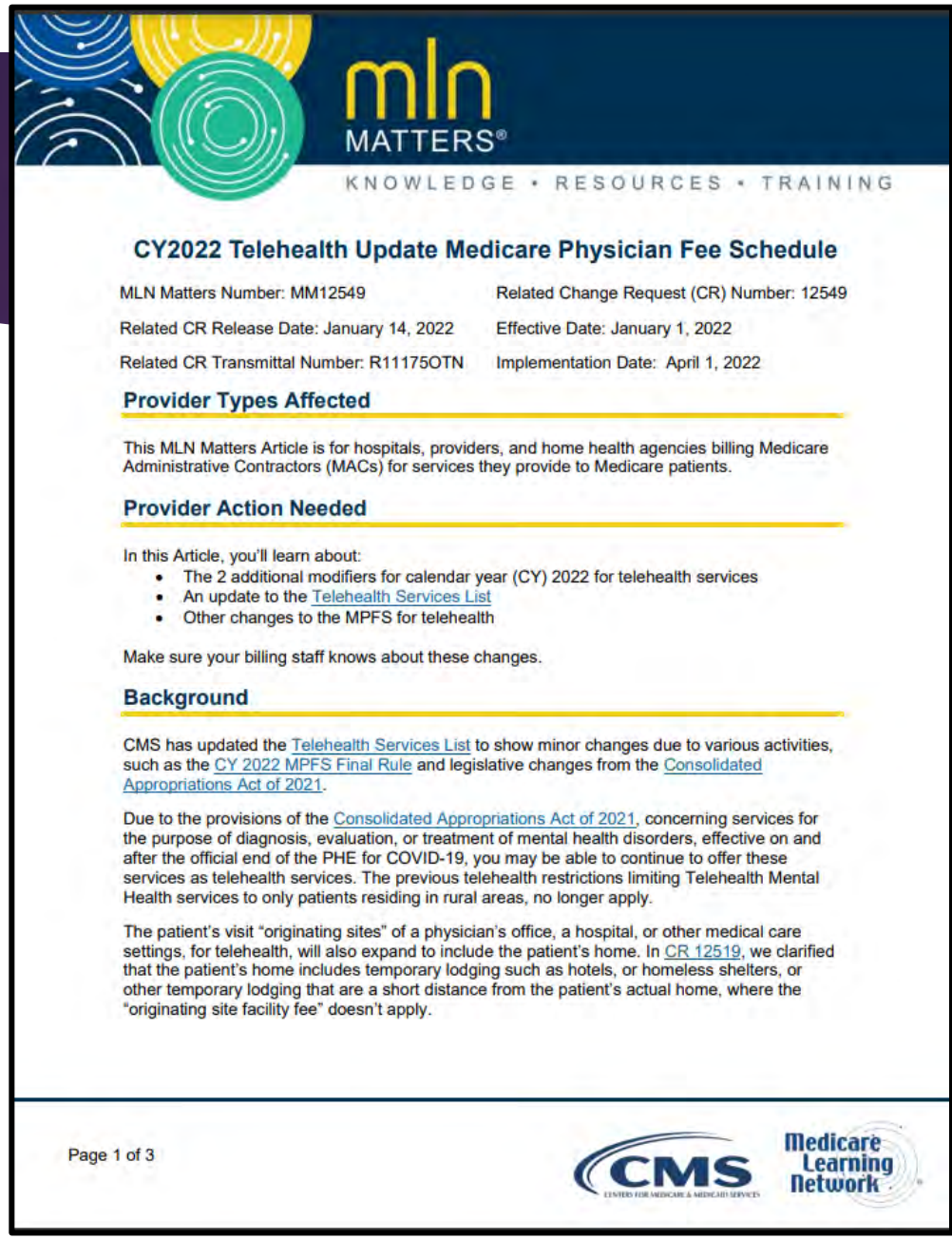
Reimbursement

Two-way live interactive video and audio between the provider and patient.
The patient must be present – if not required to be present – is not considered TeleHealth.
It is not TeleHealth for the purposes of reimbursement if the connection between a provider and patient is on the same campus.

General Principles for Reimbursement

1. TeleHealth = In-person Care
2. Bill the same as in-person care
3. Must complete all the required components for assessment and physical exam
4. If it isn't documented, it wasn't done!

Medicare, Medicaid, Private Pay, Self-Pay



mln MATTERS®

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CY2022 Telehealth Update Medicare Physician Fee Schedule

MLN Matters Number: MM12549 | Related Change Request (CR) Number: 12549

Related CR Release Date: January 14, 2022 | Effective Date: January 1, 2022

Related CR Transmittal Number: R11175OTN | Implementation Date: April 1, 2022

Provider Types Affected

This MLN Matters Article is for hospitals, providers, and home health agencies billing Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

In this Article, you'll learn about:

- The 2 additional modifiers for calendar year (CY) 2022 for telehealth services
- An update to the Telehealth Services List
- Other changes to the MPFS for telehealth

Make sure your billing staff knows about these changes.

Background

CMS has updated the Telehealth Services List to show minor changes due to various activities, such as the CY 2022 MPFS Final Rule and legislative changes from the Consolidated Appropriations Act of 2021.

Due to the provisions of the Consolidated Appropriations Act of 2021, concerning services for the purpose of diagnosis, evaluation, or treatment of mental health disorders, effective on and after the official end of the PHE for COVID-19, you may be able to continue to offer these services as telehealth services. The previous telehealth restrictions limiting Telehealth Mental Health services to only patients residing in rural areas, no longer apply.

The patient's visit "originating sites" of a physician's office, a hospital, or other medical care settings, for telehealth, will also expand to include the patient's home. In CR 12519, we clarified that the patient's home includes temporary lodging such as hotels, or homeless shelters, or other temporary lodging that are a short distance from the patient's actual home, where the "originating site facility fee" doesn't apply.

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

www.cms.gov/telehealth

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network

Algorithm for Medicare Reimbursement

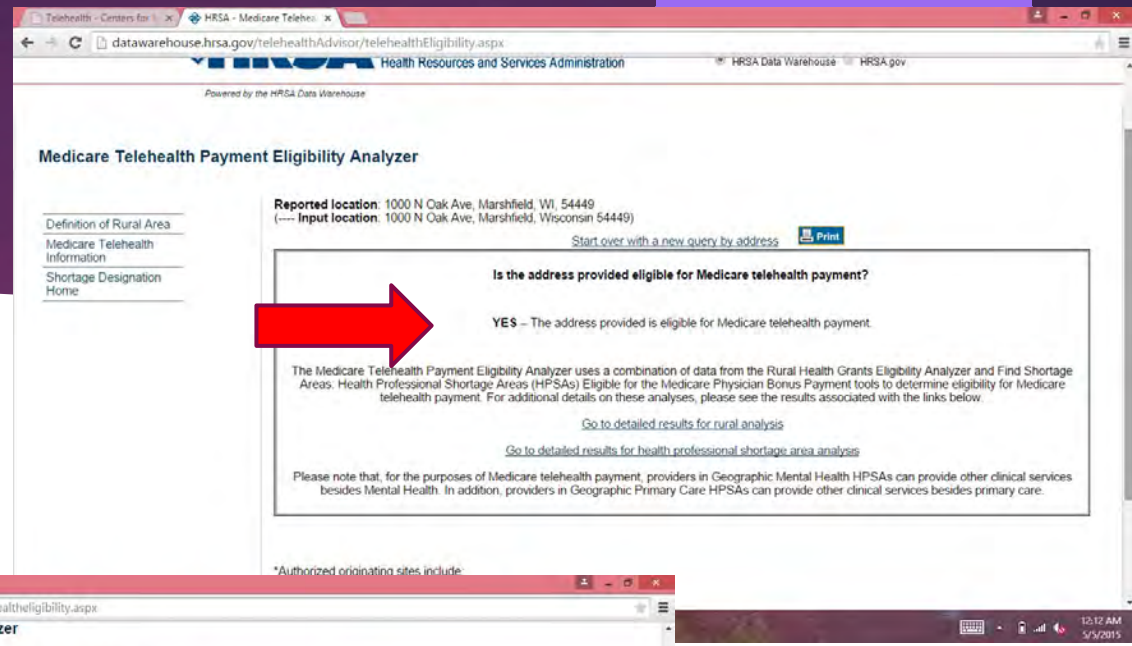
Patient Outside of A MSA

Patient in Designated Originating Site

Services within CPT code Range

Services Delivered by Eligible Practitioner

Bill Medicare!


datawarehouse.hrsa.gov/telehealthAdvisor/telehealthEligibility.aspx
Health Resources and Services Administration
HRSA Data Warehouse
HRSA.gov
Powered by the HRSA Data Warehouse
Medicare Telehealth Payment Eligibility Analyzer
Definition of Rural Area
Medicare Telehealth Information
Shortage Designation Home
Reported location: 1000 N Oak Ave, Marshfield, WI, 54449
(---- Input location: 1000 N Oak Ave, Marshfield, Wisconsin 54449)
Start over with a new query by address
Print
Is the address provided eligible for Medicare telehealth payment?
YES – The address provided is eligible for Medicare telehealth payment.
The Medicare Telehealth Payment Eligibility Analyzer uses a combination of data from the Rural Health Grants Eligibility Analyzer and Find Shortage Areas: Health Professional Shortage Areas (HPSAs) Eligible for the Medicare Physician Bonus Payment tools to determine eligibility for Medicare telehealth payment. For additional details on these analyses, please see the results associated with the links below.
Go to detailed results for rural analysis
Go to detailed results for health professional shortage area analysis
Please note that, for the purposes of Medicare telehealth payment, providers in Geographic Mental Health HPSAs can provide other clinical services besides Mental Health. In addition, providers in Geographic Primary Care HPSAs can provide other clinical services besides primary care.
*Authorized originating sites include:
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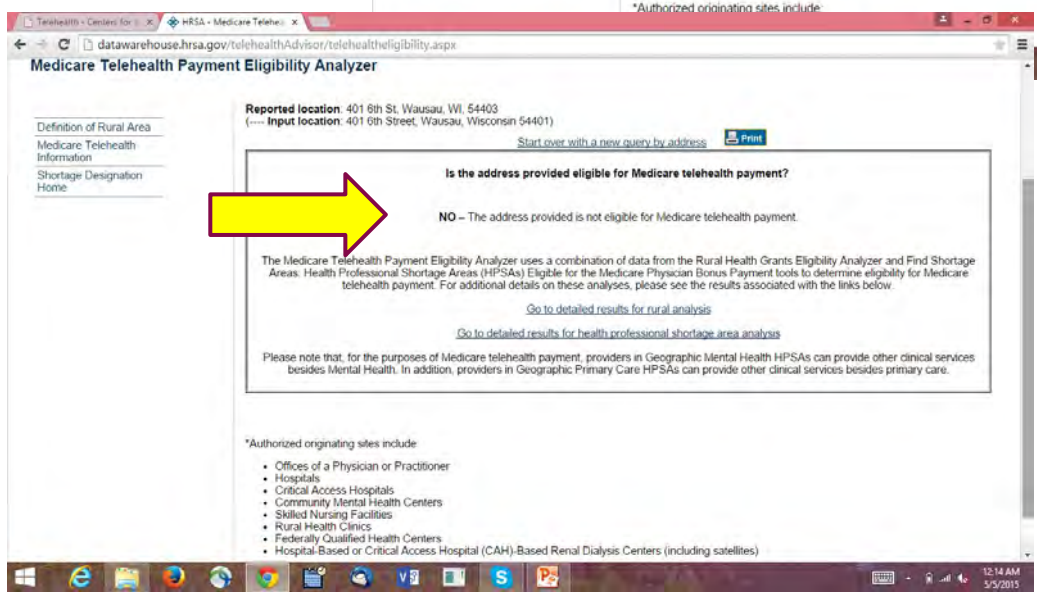
5/5/2015


datawarehouse.hrsa.gov/telehealthAdvisor/telehealtheligibility.aspx
Medicare Telehealth Payment Eligibility Analyzer
Definition of Rural Area
Medicare Telehealth Information
Shortage Designation Home
Reported location: 401 6th St, Wausau, WI, 54403
(---- Input location: 401 6th Street, Wausau, Wisconsin 54401)
Start over with a new query by address
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NO – The address provided is not eligible for Medicare telehealth payment.
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*Authorized originating sites include
Offices of a Physician or Practitioner
Hospitals
Critical Access Hospitals
Community Mental Health Centers
Skilled Nursing Facilities
Rural Health Clinics
Federally Qualified Health Centers
Hospital-Based or Critical Access Hospital (CAH)-Based Renal Dialysis Centers (including satellites)
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5/5/2015

Originating Sites

***County outside of a Metropolitan Statistical Area (MSA)**
***Rural Health Professional Shortage Area in a rural census tract**

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

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removed originating site geographic conditions and added an individual's home as a permissible originating telehealth services substance use disorder or co-occurring mental health treatment site.

Note: Medicare doesn't apply originating site geographic conditions to hospital-based and CAH-based renal dialysis centers, renal dialysis facilities, and patient homes when practitioners provide monthly ESRD-related medical evaluations in patient homes. Independent Renal Dialysis Facilities aren't eligible originating sites.

CY 2018 Medicare Telehealth Services

Service	HCPCS/CPT Code
Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425–G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406–G0408
Office or other outpatient visits	CPT codes 99201–99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231–99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307–99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150–96154
Individual psychotherapy	CPT codes 90832–90834 and 90836–90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	CPT code 90963
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	CPT code 90964

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents	CPT code 90965
End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients 20 years of age and older	CPT code 90966
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age (effective for services furnished on and after January 1, 2017)	CPT code 90967
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 2-11 years of age (effective for services furnished on and after January 1, 2017)	CPT code 90968
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 12-19 years of age (effective for services furnished on and after January 1, 2017)	CPT code 90969
End-Stage Renal Disease (ESRD)-related services for dialysis less than a full month of service, per day; for patients 20 years of age and older (effective for services furnished on and after January 1, 2017)	CPT code 90970
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802–97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443

Approved CPT Codes

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
Annual depression screening, 15 minutes	HCPCS code G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	CPT code 99496
Advance Care Planning, 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99497
Advance Care Planning, additional 30 minutes (effective for services furnished on and after January 1, 2017)	CPT code 99498
Psychoanalysis	CPT code 90845
Family psychotherapy (without the patient present)	CPT code 90846
Family psychotherapy (conjoint psychotherapy) (with patient present)	CPT code 90847
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour	CPT code 99354
Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes	CPT code 99355
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; first hour (list separately in addition to code for inpatient evaluation and management service)	CPT code 99356

CY 2018 Medicare Telehealth Services (cont.)

Service	HCPCS/CPT Code
Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service; each additional 30 minutes (list separately in addition to code for prolonged service)	CPT code 99357
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) first visit	HCPCS code G0438
Annual Wellness Visit, includes a personalized prevention plan of service (PPPS) subsequent visit	HCPCS code G0439
Telehealth Consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)	HCPCS code G0508
Telehealth Consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth (effective for services furnished on and after January 1, 2017)	HCPCS code G0509
Counseling visit to discuss need for lung cancer screening using low dose CT scan (LDCT) (service is for eligibility determination and shared decision making (effective for services furnished on and after January 1, 2018)	HCPCS code G0296
Interactive Complexity Psychiatry Services and Procedures (effective for services furnished on and after January 1, 2018)	CPT code 90785
Health Risk Assessment (effective for services furnished on and after January 1, 2018)	CPT codes 96160 and 96161
Comprehensive assessment of and care planning for patients requiring chronic care management (effective for services furnished on and after January 1, 2018)	HCPCS code G0506
Psychotherapy for crisis (effective for services furnished on and after January 1, 2018)	CPT codes 90839 and 90840

For ESRD-related services, a physician, NP, PA, or CNS must furnish at least one "hands on" visit (not telehealth) each month to examine the vascular access site.

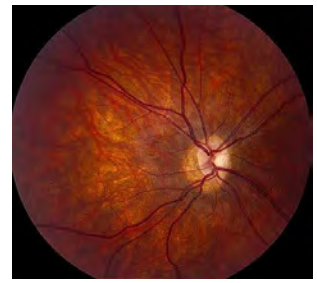
Payer's Eligible Practitioners (CMS)

- Physician
- Nurse Practitioner
- Physician Assistant
- Clinical Nurse Specialist
- Certified Nursing Anesthetist
- Nurse Midwife
- Registered Dieticians or Nutrition Professional
- Clinical Social Worker
- Clinical Psychologist

  - **CPs and CSWs can't bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They can't bill or get paid for CPT codes 90792, 90833, 90836, and 90838.**

Specific TeleHealth Provisions (CMS)

- Skilled Nursing Facility – frequency
- Dialysis – does not include mandated visit 90962
- Subsequent hospital care – every 3 days for attending
- Annual Wellness Exam G0438 – 39
- Prolonged Services 99394 – 95
- Mobile Retinal Screening 99227 – 28



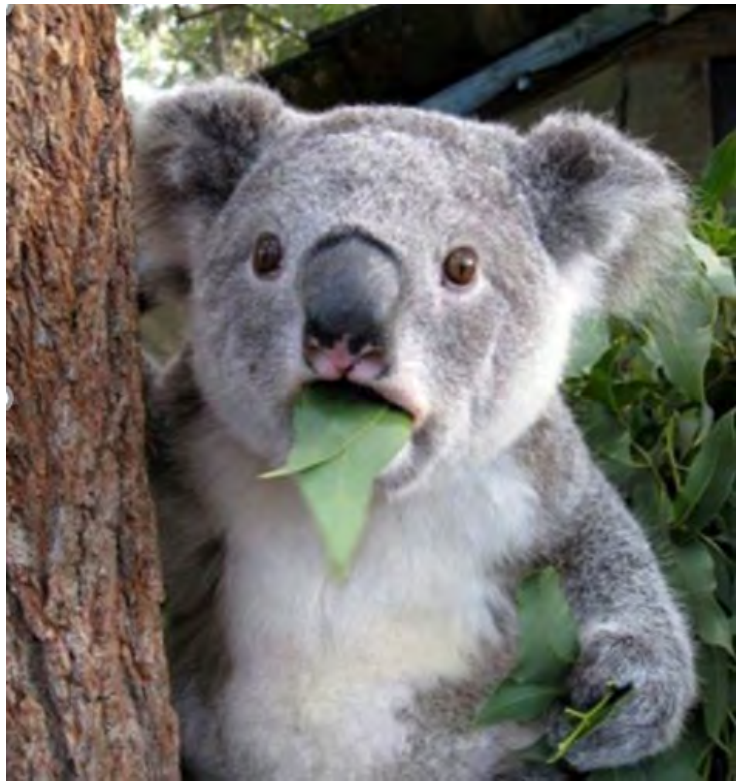
Requirements for Virtual Communication G0071 for FQHCs and RHCs (CMS)

- Must be initiated by the patient;
- At least 5 minutes of communication technology-based or remote evaluation services are furnished by an RHC or FQHC practitioner to a patient;
- Patient who has had an RHC or FQHC 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 or FQHC service provided within the previous 7 days; and
  - The medical discussion or remote evaluation does not lead to an RHC or FQHC visit within the next 24 hours or at the soonest available appointment.

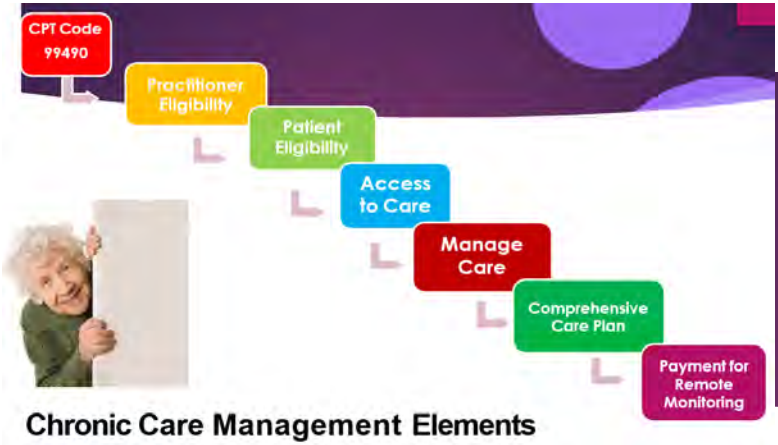
2019 CMS Additional CPT/HCPCs Services

1. **Brief Communication Technology- Based Service, e.g., Virtual Check-In (HCPCS Code GVCI1)**
2. **Interprofessional Internet Consultation: CPT Codes**
   - **CPT code 994X0 (Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes).**
   - **CPT code 994X6 (Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time).**

Brief Communication Visit 994x0 and 994x6



- ✓ For Medicare only as described
- ✓ Established patients only
- ✓ Requires consent of the patient
- ✓ Documentation requirements listed
- ✓ Cannot be seen for the same condition within the last seven or the next seven days



Additional CMS CPT Services 2019

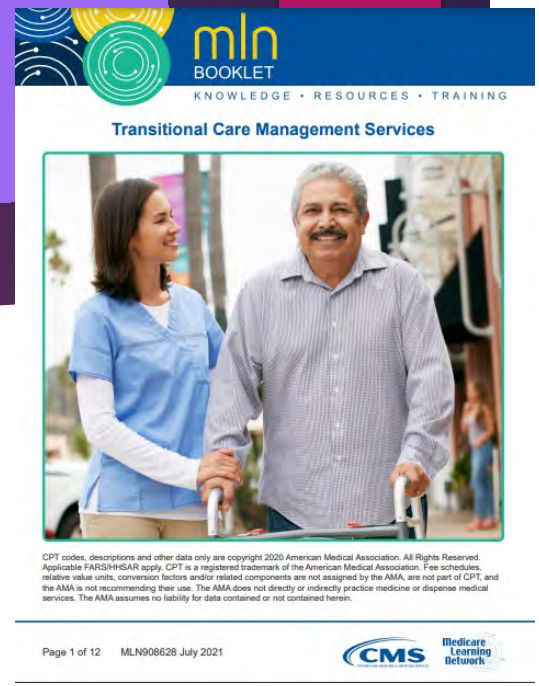
Chronic Care Remote Physiologic Monitoring: CPT Codes

- **CPT code 990X0** (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment).
- **CPT code 990X1** (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days).
- **CPT code 994X9** (Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month).

Transitional Care Elements

CPT Code 99495-6

- **Practitioner Eligibility**
- **Patient Eligibility**
- **Additional Team Members**
- **Required Interactive Contact**
- **One Face-to-face visit Required**
- **May be Done by TeleHealth**



mln BOOKLET

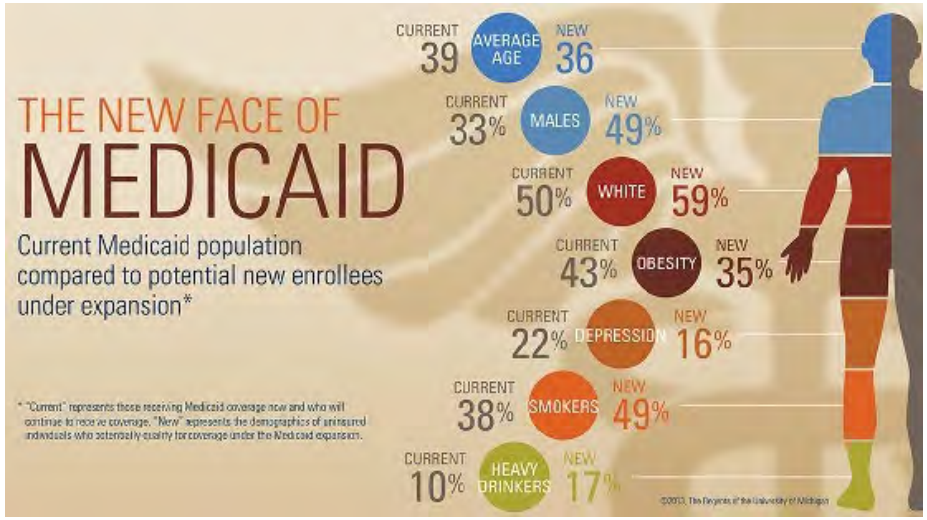
KNOWLEDGE • RESOURCES • TRAINING

Transitional Care Management Services

CMS Medicare Learning Network

Medicaid

- Different in all 52 states
- Many have Telehealth Parity Laws
- Some follow Medicare
- May be more advanced than Medicare
- Published fee schedule
- Need to check each state

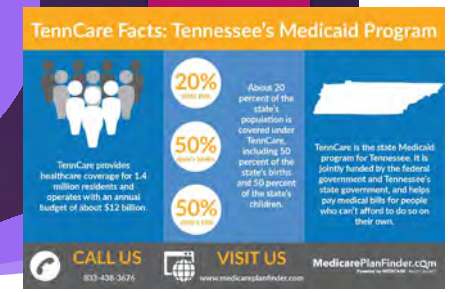


Tennessee State's Medicaid and TeleHealth

Tennessee Code Annotated § 56-7-1002

1. **Telemedicine Parity Law**
2. **Equal access and payment**
3. **Not required to pay unless service is a benefit or other offering by the health plan for in-person care**
4. **Includes Medicaid, Medicaid MCOs, and Medicare Advantage plans (section § 56-7-109)** Tenn. Code Ann. § 56-7-1002

Tennessee Telehealth Definitions



Tennessee Medical Board

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(Tenn. Comp. R. & Regs. 0880-02-.16)

TennCare Medicaid

Telehealth is defined as the use of electronic information and communication technologies to deliver health care to patients at a distance. Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management, and/or self-management of a Medicaid member.

(https://www.tn.gov/content/dam/tn/tenncare/documents/TennCareTelephonicProgramDescription.pdf Accessed 4-20-2022)

Tennessee Telehealth Parity Law

TN Parity Law Definition of Telehealth for Payment Purposes (2014-2020 revisions)

(7) **"Telehealth":**

(A) Means the use of **real-time, interactive audio, video telecommunications or electronic technology, or store-and-forward telemedicine services** by a healthcare services provider to deliver healthcare services to a patient within the scope of practice of the healthcare services provider when:

(i) Such provider is at a **qualified site other than the site where the patient is located**; and

(ii) The **patient is at a qualified site, at a school clinic** staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section, or at a public elementary or secondary school staffed by a healthcare services provider and equipped to engage in the telecommunications described in this section; and

(B) Does not include:

(i) An audio-only conversation;

(ii) An electronic mail message; or

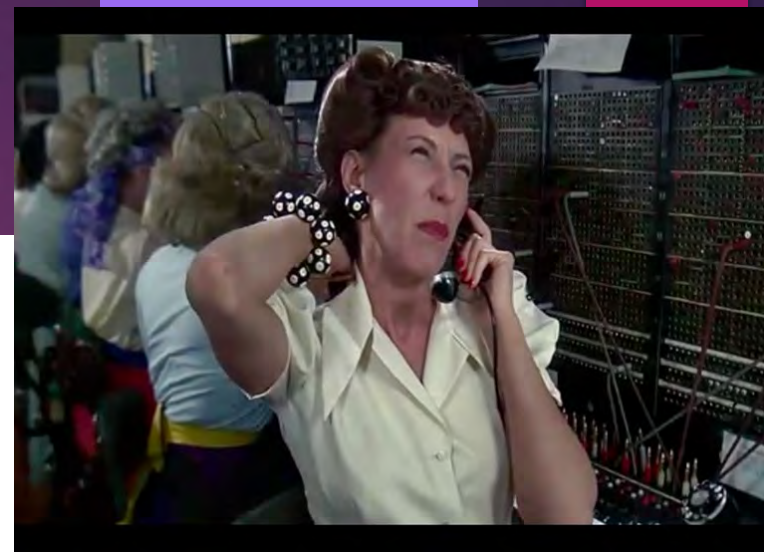
(iii) A facsimile transmission; and

(8) "Telehealth provider" means a healthcare services provider engaged in the delivery of healthcare services through telehealth.

Cigna

Humana

of Tennessee

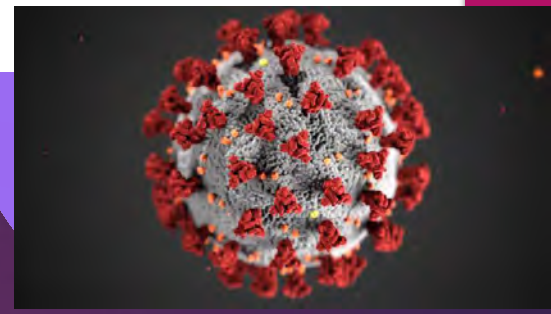


UnitedHealthcare

MOLINA HEALTHCARE

The Magic of Getting Paid by Private Health Plans

COVID-19 PANDEMIC



- There's no sense in wasting a good crisis!
- Waivers on the restrictions for CMS reimbursement
- Waivers on licensing
- Waivers on HIPAA compliant software
- Waivers from private payers
- Few waivers from Medicaid agencies
- Gubnatorial Emergency Orders
  - Licensure

Where are We Now Post-Covid

- ✓ **PHE Federally extended to January 11, 2023**
- ✓ **Initial CMS Waivers**
  - ✓ Provided waiver authority under section 1135 of the Act to create flexibilities in the requirements of section 1834(m)(1) of the Act and 42 CFR § 410.78 for use of interactive telecommunications systems to furnish telehealth services
  - ✓ Created further PHE flexibilities to the requirements of section 1834(m)(1) of the Act and 42 CFR § 410.78(a)(3)
  - ✓ Allowed for the use of audio-only equipment to furnish services described by the codes for audio-only telephone evaluation and management services, and behavioral health counseling and educational services
  - ✓ Waived the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2), which specify the types of practitioners who may bill for their services when furnished as Medicare telehealth services from a distant site

General Caveats to Basic Medicare Approach and Other Requirements

- ✓ **Modified the process to add services to the Medicare Telehealth Services List during the PHE, allowing us to consider adding appropriate services on a sub-regulatory basis, as they were requested, as practitioners were actively learning how to use telehealth**
- ✓ **Clinicians can provide remote evaluation of patient video/images and virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients**
- ✓ **Allowed for audio only technology, practitioners have been able to bill using these telephone E/M codes provided that it is appropriate to furnish the service using audio-only technology and all of the required elements in the applicable telephone E/M code (99441-99443) description are met**
- ✓ **Allowed many behavioral health and education services to be furnished via telehealth using audio-only communications**

- ✓ permitted clinicians to bill for remote patient monitoring (RPM) services furnished to both new and established patients, and to patients with both acute and chronic conditions
- ✓ allow clinicians to bill CPT codes 99453 and 99454 when as few as two days of data were collected if the patient was diagnosed with, or was suspected of having, COVID-19 and as long as all other billing requirements of the codes were met
- ✓ removed the frequency restrictions for the following listed codes furnished via Medicare telehealth
- ✓ Allowed home dialysis patient to receive the monthly and every three months in-person visit vis Telehealth
- ✓ Waived the requirements of National Coverage Determination or Local Coverage Determination so that services could be delivered via Telehealth
- ✓ Allowed for beneficiary consent to be obtained for virtual check-ins at the same times as the services are furnished for new and established patients
- ✓ Created flexibilities allowing physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted

Opioid Treatment Programs (OTPs)

- ✓ **Patient counseling and therapy provided by telephone in cases where two-way interactive audio-video communication technology is not available to the beneficiary, and all other applicable requirements are met**
- ✓ **Periodic assessments have been conducted via two-way interactive audio-video communication technology and may have been provided by telephone, only in cases where the beneficiary has not had access to two-way interactive audio-video communication technology and all other applicable requirements have been met**
- ✓ **Flexibility has been made permanent for OTPs in the CY 2022 PFS final rule**

Where are We Now?

Consolidated Appropriations Act of 2020

- Allowed for mental and behavioral health services to be provided in the home with no geographic restrictions
- Must have a Medicare billable service via in-person visit within six months prior to the Telehealth DOS
- Must have an in-person visit 12 months prior to the telehealth services with some exceptions

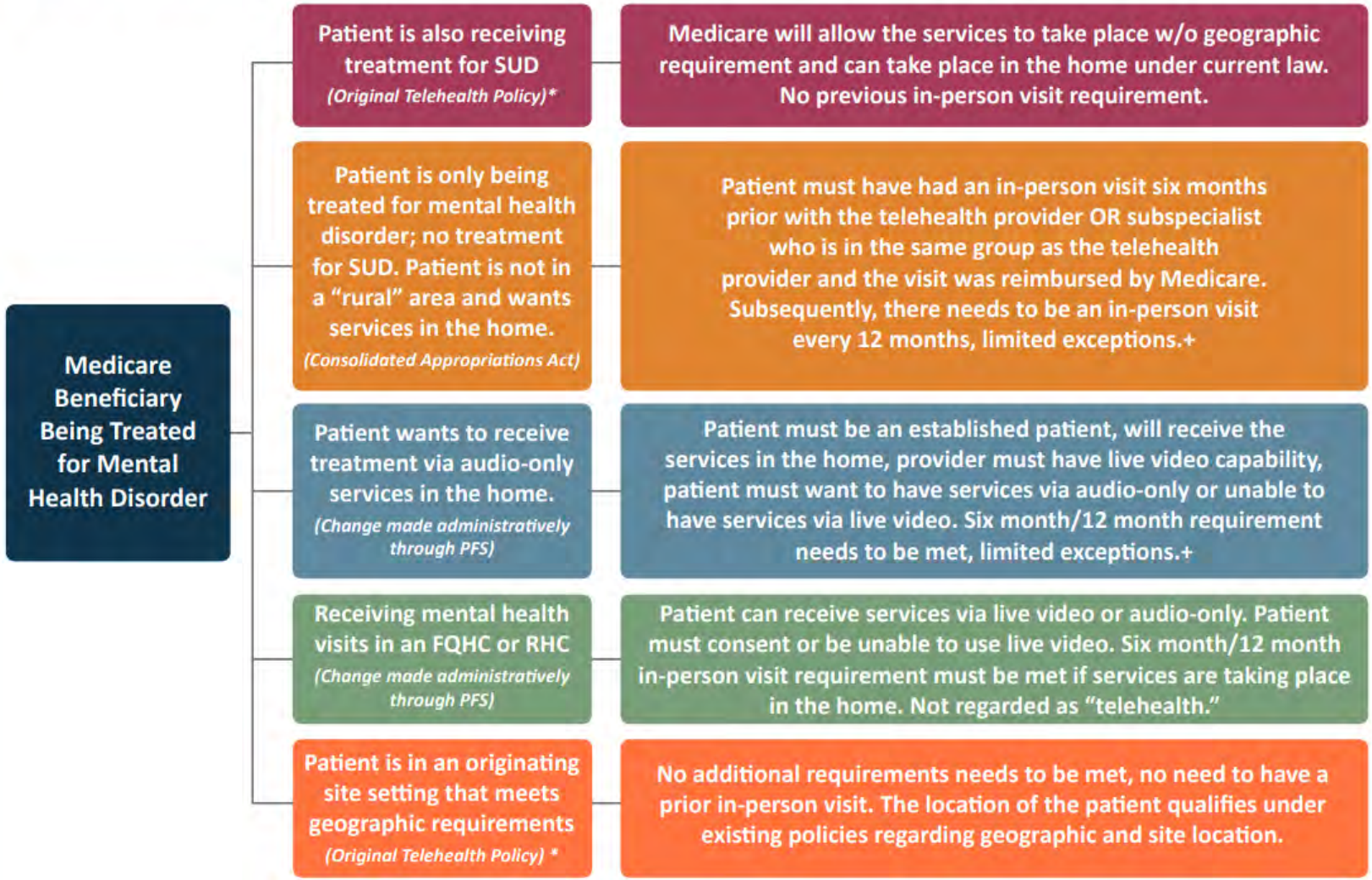
Budget Act of 2022

- Delayed implementation of policies and extended expiration dates on temporary waivers (some) until 151 days after the PHE is over

CMS Physician Fee Schedule 2022

- **Audio-only allowed to for mental health services with certain conditions met**
  - Added the word 'interactive' to the term 'telecommunications system'
  - For established patients only
  - Home is now an originating site for mental health services
  - Previous 6 month in-person visit and subsequent 12 month in-person visit requirements
  - Provider must have capability of live video but patient can choose audio only
- **Allows definition of mental health visits to include live video and audio-only visits for FQHCs and RHCs**
  - Cannot act as originating sites
  - Redefined mental health visit to include encounters furnished through interactive, real-time telecommunications technology when furnishing services for the purposes of diagnosis, evaluation, or treatment of a mental health disorder
  - Only when the patient is not capable or does not want to use video
  - Subject to the six and 12 month in-person requirements

CY 2022 MEDICARE REIMBURSEMENT FOR MENTAL HEALTH SERVICES VIA TELEHEALTH & AUDIO-ONLY



* Original Telehealth Policy refers to the existing telehealth policy in federal statute that existed prior to the Consolidated Appropriations Act.
\+ Limited exceptions to the 12 month in-person visit include when the provider and patient agree the risks to patient's care outweighs the need for the in-person visit.

Rehabilitation and Virtual Check-in Services 2022

- **Added codes to the list of Telehealth Services:**
  - **93797 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)**
  - **93798 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)**
  - **G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise (per session)**
  - **G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise (per session)**
  - **G2252 – made permanent. G2252 is defined as a brief communication technology-based service, virtual check-in service, by physician or other qualified health care professional who can report E/M services, provided to an established patient, with other conditions**

Remote Therapeutic Monitoring 2022

- **98975 – Remote therapeutic monitoring initial set up and patient education on use of equipment.**
- **98976 – Remote therapeutic monitoring with device(s) supply with scheduled recording(s) and/ or programmed alert(s) transmission(s) to monitor respiratory system, each 30 days.**
- **98977 - Remote therapeutic monitoring with device(s) supply with scheduled recording(s) and/ or programmed alert(s) transmission(s) to monitor musculoskeletal system, each 30 days).**
- **98980 – Remote therapeutic monitoring treatment management services physician/ other qualified health professional's time in a calendar month requiring at least one interactive communication with the patient/caregiver in a calendar month, first 20 minutes.**

Principle Care Management (PCM) and Chronic Care Management (CCM) 2022

- 99437 – CCM service each additional 30 minutes by a physician or other qualified health care professional, per calendar month.
- 99424 – PCM services for a single high-risk disease first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
- 99425 – PCM services for a single high-risk disease each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.
- 99426 – PCM for a single high-risk disease first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.
- 99427 – PCM for a single high -risk disease each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

How Do We Get New CMS Telehealth Services?

Category 1 Services

- ✓ Similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare Telehealth Services List.

Category 2 Services

- ✓ Not similar to those on the current Medicare Telehealth Services List. 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.

Category 3 Services

- ✓ Services that were added to the Medicare Telehealth Services List during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria.

HCPCS	Long Descriptor	Basis
	Code Family	
	Lactation classes	
S9443	Lactation classes, non-physician provider, per session	
	Telephone E/M	
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	3
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	3
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	3
	Therapy	
90901	Biofeedback training by any modality	1
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	1
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	1
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)	1
97150	Therapeutic procedure(s), group (2 or more individuals)	1
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.	1
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family.	1
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family.	1
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family.	1
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	1
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes	1
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes	1
97542	Wheelchair management (e.g., assessment, fitting, training), each 15 minutes	1
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes	1
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes	1
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	1
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	1
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	1
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	1
	Gastrointestinal tract imaging	
91110	Gastrointestinal tract imaging, intraluminal (e.g., capsule endoscopy), esophagus through ileum, with interpretation and report	3
	Ambulatory continuous glucose monitoring	
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report	N/A
	Electronic analysis of implanted neurostimulator pulse generator/transmitter	
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1
95977	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	1
95970	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve, neurostimulator pulse generator/transmitter, without programming	3
95983	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, first 15 minutes face-to-face time with physician or other qualified health care professional	3
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (e.g., contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)	3
	Adaptive behavior treatment and Behavior identification assessment	
97151	Behavior identification assessment, administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan	2
97152	Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient, each 15 minutes	2
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes	2
97154	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes	2
97155	Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes	2
97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes	2
97157	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes	2
97158	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, face-to-face with multiple patients, each 15 minutes	2
0362T	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	2
0373T	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: administration by the physician or other qualified health care professional who is on site; with the assistance of two or more technicians; for a patient who exhibits destructive behavior; completion in an environment that is customized to the patient's behavior.	2

Services Finalized for Addition to the Medicare Telehealth Services List Category 1

HCPCS	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other QHP
G0317	Prolonged nursing facility services by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain txment monthly bundle including…30 min
G3003	Chronic pain txment monthly bundle including…each additional 15 min

12% of total requests

Services Finalized for Addition to the Medicare Telehealth Services List Category 3 through CY 2023

HCPCS	Short Descriptor
90875	Psychophysiological therapy
90901	Biofeedback train any meth
92012	Eye exam estab pat
92014	Eye exam & tx estab pt 1/>vst
92507	Speech/hearing therapy
92550	Tympanometry & reflex thresh
92552	Pure tone audiometry air
92553	Audiometry air & bone
92555	Speech threshold audiometry
92556	Speech audiometry complete
92557	Comprehensive hearing test
92563	Tone decay hearing test
92565	Stenger test pure tone
92567	Tympanometry
92568	Acoustic refl threshold tst
92570	Acoustic immitance testing
92587	Evoked auditory test limited
92588	Evoked auditory tst complete
92601	Cochlear implt f/up exam <7
92625	Tinnitus assessment
92626	Eval aud funcj 1st hour
92627	Eval aud funcj ea addl 15
94005	Home vent mgmt supervision
95970	Alys npgt w/o prgrmg
95983	Alys brn npgt prgrmg 15 min
95984	Alys brn npgt prgrmg addl 15
96105	Assessment of aphasia
96110	Developmental screen w/score
96112	Devel tst phys/qhp 1st hr
96113	Devel tst phys/qhp ea addl
96127	Brief emotional/behav assmt
96170	Hlth bhv ivntj fam wo pt 1st
96171	Hlth bhv ivntj fam w/o pt ea
97129	Ther ivntj 1st 15 min
97130	Ther ivntj ea addl 15 min
97150	Group therapeutic procedures
97151	Bhv id assmt by phys/qhp
97152	Bhv id suprt assmt by 1 tech
97153	Adaptive behavior tx by tech
97154	Grp adapt bhv tx by tech
97155	Adapt behavior tx phys/qhp
97156	Fam adapt bhv tx gdn phy/qhp
97157	Mult fam adapt bhv tx gdn
97158	Grp adapt bhv tx by phy/qhp
97530	Therapeutic activities
97537	Community/work reintegration
97542	Wheelchair mngment training
97763	Orthc/prostc mgmt sbsq enc
98960	Self-mgmt educ & train 1 pt
98961	Self-mgmt educ/train 2-4 pt
98962	Self-mgmt educ/train 5-8 pt
99473	Self-meas bp pt educaj/train
0362T	Bhv id suprt assmt ea 15 min
0373T	Adapt bhv tx ea 15 min

Behavioral Health Services

- Considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as *licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs).*
- Finalizing the proposal to *add an exception to the direct supervision requirement* under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP).
- Clarifying that *any service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel* under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services.
- Indicated in the final rule that CMS intends to address payment for *new codes that describe caregiver behavioral management training in CY 2024 rulemaking*.
- Finalizing a proposal to create a *new General BHI code describing a service personally performed by CPs or clinical social workers (CSWs)* to account for monthly care integration where the mental health services furnished by a CP or CSW are serving as the focal point of care integration.
- Finalizing the proposal *to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.*

"CMS PAID PRACTITIONERS FOR TELEHEALTH SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS"
OIG 2018 REPORT

- Reviewed 191,118 Medicare paid distant-site telehealth claims
- Years 2014 and 2015
- Did not have corresponding originating-site claims
- Claims totaled $13,795,384
- Stratified random sample of 100 claims (0.0005%)
- Supporting documentation – to determine whether paid telehealth services were allowable in accordance with Medicare requirements

"CMS PAID PRACTITIONERS FOR TELEHEALTH SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS" OIG 2018 REPORT CON'T…

- 24 claims were unallowable – beneficiaries received services at non-rural originating sites – some examples office located in MSA
- 7 claims were billed by ineligible institutional providers;
- 3 claims were for services provided to beneficiaries at unauthorized originating (home, free-standing dialysis center)
- 2 claims were for services provided by an unallowable means of (telephone, asynchronous)
- 1 claim was for a noncovered service; and
- 1 claim was for services provided by a physician located outside the United States

U.S. Department of Health and Human Services
Office of Inspector General

Questions?????

OIG Finding	Question
24 claims were unallowable – beneficiaries received services at non-rural originating sites – some examples office located in MSA	1. Provider organization or third-party MAC billing entity 2. Who? Technical component or pro fee? What is an institutional provider? 3. How many of these claims were the same provider? 4. How many of the claims were the same organization? 5. How many claims were coded and billed out by a third-party company?
7 claims were billed by ineligible institutional providers	
3 claims were for services provided to beneficiaries at unauthorized originating (home, free-standing dialysis center)	
2 claims were for services provided by an unallowable means of (telephone, asynchronous)	
1 claim was for a noncovered service; and	
1 claim was for services provided by a physician located outside the United States	

MEDPAC:
Mandated report: Telehealth Services and the Medicare Program

Mandate: Section 4012 of the 21st Century Cures Act

(b) **Provision of information by MedPAC**—Not later than March 15, 2018, the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6) shall, using quantitative and qualitative research methods, provide information to the committees of jurisdiction of the House of Representatives and the Senate that identifies—

1. the telehealth services for which payment can be made, as of the date of enactment of this Act, under the fee-for-service program under parts A and B of title XVIII of such Act;
2. the telehealth services for which payment can be made, as of such date, under private health insurance plans; and
3. with respect to services identified under paragraph (2) but not under paragraph (1), ways in which payment for such services might be incorporated into such fee-for-service program (including any recommendations for ways to accomplish this incorporation). ■

MEDPAC *Advising the Congress on Medicare issues*

TABLE 16–1 **Coverage of telehealth services across Medicare payment systems, 2018**

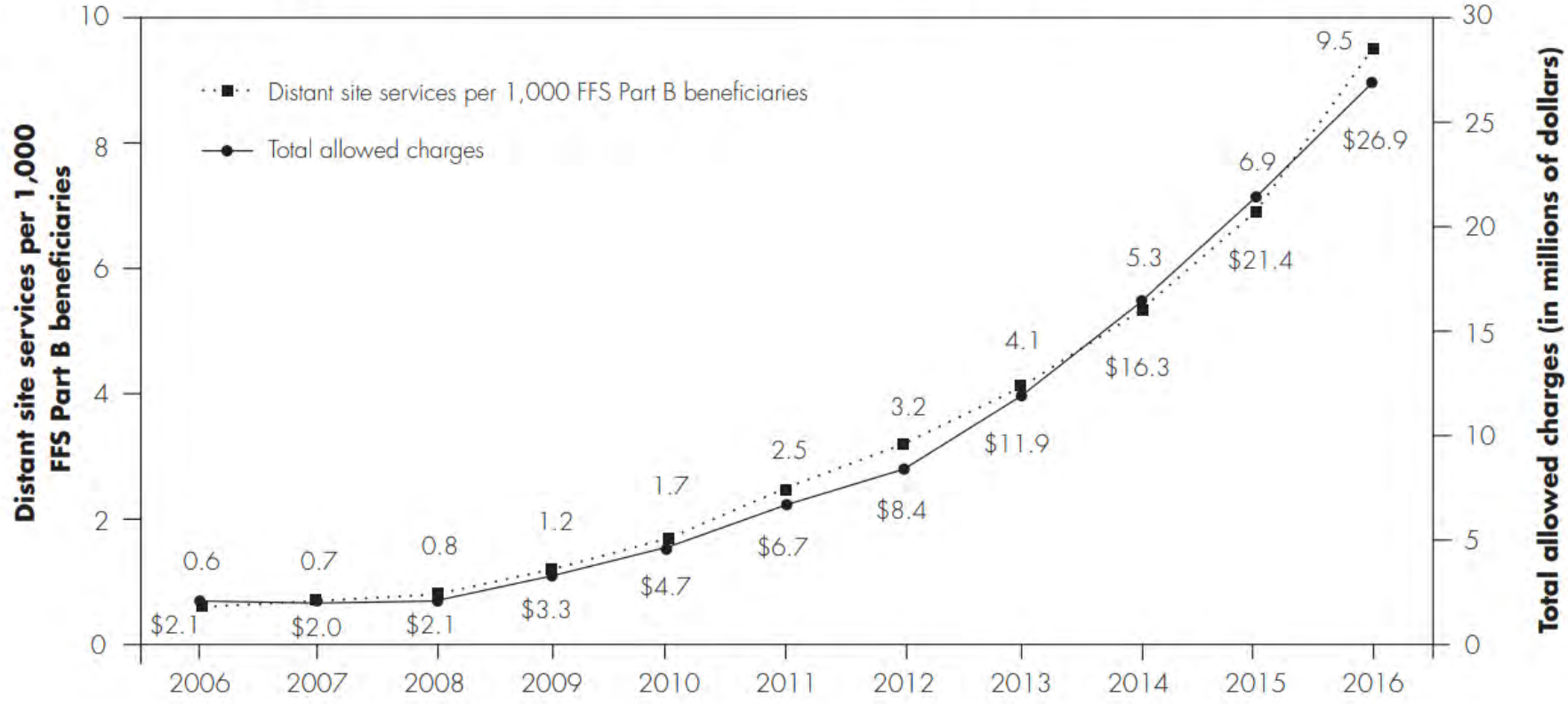
Medicare payment system	Total program spending: Dollars (in billions)	Total program spending: Percent	Telehealth coverage	Description of payment for telehealth services	Provider/plan incentives for telehealth use
Fee-for-service: Physician fee schedule	$70	12%	Limited to rural locations, certain services, and two-way video; originating sites must be facilities	Separate payment for each discrete service	Increase use without explicit incentive to control costs
Fee-for-service: IPPS/OPPS hospital, IRF, LTCH, ESRD, ASC, SNF, HH, hospice	$269	46	Flexibility to use telehealth services that best treat the patient	Payment contemplated as a part of a fixed payment for each patient encounter	Use telehealth if it reduces costs; at risk if cost of encounter exceeds fixed payment
Medicare Advantage	$170	29	Must mirror Medicare FFS coverage and have flexibility to offer services beyond the PFS	Capitated payment includes telehealth services covered under PFS, but extra telehealth services must be financed with supplemental premiums or rebate dollars	Use telehealth if it reduces costs; at risk if annual beneficiary costs exceed payment
ACOs (two-sided risk)	N/A	N/A	Waiver to provide telehealth services in urban locations and from patients' homes	Separate payment for each discrete service, but receive a bonus payment if annual costs are lower than spending target	Use telehealth if it reduces costs; will not receive bonus payment if annual beneficiary costs exceed target

Note: IPPS (inpatient hospital prospective payment system), OPPS (outpatient hospital prospective payment system), IRF (inpatient rehabilitation facility), LTCH (long-term care hospital), ESRD (end-stage renal disease), ASC (ambulatory surgical center), SNF (skilled nursing facility), HH (home health), FFS (fee-for-service), PFS (physician fee schedule; also referred to as the fee schedule for physicians and other health professionals), ACO (accountable care organization), N/A (not applicable). Total system spending includes payment for all services. Percentages of spending across the Medicare payment systems do not sum to 100 percent because Medicare Part D ($80 billion in 2015) is not shown. Therefore, the denominator used to calculate the percentages in the third column includes spending for the PFS, all other FFS systems, Medicare Advantage, and Part D. ACO-related spending is included in the two FFS payment system categories. Home health agencies and hospices are not permitted to include the cost of telehealth services in their annual cost reports; as a result, these costs are not built into their payment rates.

Source: MedPAC analysis of CMS claims data files and and fiscal year/calendar year 2018 final rule regulations

FIGURE 16–1

Utilization of Medicare physician fee schedule distant site telehealth visits per 1,000 FFS Part B beneficiaries and total allowed charges for telehealth visits, 2006 to 2016



Note: FFS (fee-for-service).

Source: CMS Carrier file claims data.

TABLE 16–3 **Medicare physician fee schedule distant site telehealth services, by type, 2016**

Type of service	Number of services	Share of distant site services	Percent change in the number of distant site services from 2014 to 2016
Office or other outpatient visits (E&M)	183,996	58%	59%
Psychotherapy	55,859	18	180
Follow-up inpatient telehealth consultations	17,959	6	129
Psychiatric diagnostic interview examination	17,091	5	32
Telehealth consultations, emergency department or initial outpatient	13,711	4	80
Subsequent nursing care services	12,115	4	263
Subsequent hospital care services	9,463	3	93
Pharmacological management	4,384	1	148
End-stage renal disease–related services	1,978	1	83
Other telehealth services	2,025	1	226
Total	318,581	100	81

Note: E&M (evaluation and management). Components may not sum to totals due to rounding.

Source: CMS Carrier file claims data.

TABLE 16–8

Illustrative examples of evaluating the value of individual telehealth services or conditions using the Commission's principles

Telehealth service	Possible expansion of physician fee schedule policy	Three principles of evaluation			
		Cost	Access	Quality	Evidence
Telestroke	Cover in urban areas	Small increase (small pool of users)	Expanded (short supply of stroke specialists)	Improved (more timely care)	Clear
Physically disabling treatment-intensive conditions	Cover in urban areas or from a patient's residence	Small increase (small pool of users)	Expanded (improved convenience)	Improved (ability to access needed care)	Clear
Tele–mental health	Cover in urban areas	Large increase (large pool of users, potential misuse)	Expanded (improved convenience)	Some improvement, but outcomes unclear	Less clear
Direct to consumer	Cover in urban areas or from a patient's residence	Very large increase (very large pool of users, potential misuse)	Expanded (improved convenience)	Unclear	Unclear
Nursing homes	Cover in urban areas	Decrease (fewer emergency department visits)	Unclear	Unclear	Unclear
Remote patient monitoring	Cover in urban areas	Very large increase (very large pool of users, potential misuse)	Expanded (improved convenience)	Improved (ability to access needed care)	Unclear

Source: MedPAC analysis.

2018 COMMISSION SUGGESTIONS

-That policy makers adopt a measured approach to considering new telehealth services into the PFS or other parts of the Medicare program;

-Supporting evaluation of individual types of telehealth services for potential coverage under Medicare using its principles of cost, access, and quality;

-if a given service demonstrates evidence of balancing cost, access, and quality, policymakers should consider implementing that service;

-when evidence is unclear, policymakers should consider testing theuse of that telehealth service through CMMI;

-that entities bearing financial risk under the Medicare program (MA plans and risk-bearing ACOs) warrant greater flexibility to use telehealth services.

U.S. Department of Health and Human Services

Office of Inspector General

Data Brief

September 2022, OEI-02-20-00720

Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks

OIG Audit Findings – What We Can Learn

- ✓ 28 million Medicare beneficiaries used Telehealth services in the first year of the PHE
- ✓ 88x more utilization than the year before the PHE
- ✓ 740,000 providers reviewed
- ✓ 1,714 providers discovered with 1 or more concerns on billing measures
- ✓ 50% + were in the same practice
- ✓ 41 providers associated with telehealth companies

CMS/OIG Program Integrity Measures

1) billing both a **telehealth service** and a **facility fee** for most visits;
2) billing telehealth services at the **highest, most expensive level** every time;
3) billing telehealth services for a **high number of days** in a year;
4) billing both **Medicare fee-for-service and a Medicare Advantage plan for the same service** for a high proportion of services;
5) billing a **high average number of hours** of telehealth services per visit;
6) billing telehealth services for a **high number of beneficiaries**; and
7) billing for a telehealth service and **ordering medical equipment** for a high proportion of beneficiaries.

Key Takeaways

1. Findings demonstrate the importance of **effective, targeted oversight of telehealth services** to ensure that the benefits of telehealth are realized while minimizing risk.
2. OIG identified 1,714 providers out of approximately 742,000 whose billing for telehealth services poses a ***high risk to Medicare*****.**
3. Each of these providers had concerning billing on at least **one of seven measures that may indicate fraud, waste, or abuse.**
4. These providers billed for telehealth services for about ***half a million beneficiaries.***
5. Many of these providers are a part of the ***same medical practice as at least one other provider whose billing poses a high risk*****.**

US Dept of Health and Human Services, OIG. Data brief: Medicare telehealth services during the firt year of the pandemic: program integrity risks. Sept 2022, OEI-o2-02-00720.

What You Can do To Ensure Billing Compliance

OIG/Medicare	YOU!
billing both a **telehealth service** and a **facility fee** for most visits	Make sure to bill FF on the 1500 form and Pro Fee on the UB form, with different POS and modifier
billing telehealth services at the **highest, most expensive level** every time	Ensure documentation and coding supports billing; do not use Level IV or V unless appropriate; usually critical care, emergency, very complex co-morbid conditions, etc.
billing telehealth services for a **high number of days** in a year	Typical office visits are the parameters for billing cycles; COVID illnesses may have added to the issue; don't see the patient just because it is easy
billing both **Medicare fee-for-service and a Medicare Advantage plan for the same service** for a high proportion of services	Really? This is just simply a no-no!
billing a **high average number of hours** of telehealth services per visit	Time-based coding principles apply and must be accurately documented
billing telehealth services for a **high number of beneficiaries**	Tricky issue; make sure that overall billing is similar to in-person payer mix; targeting Medicare beneficiaries
billing for a telehealth service and **ordering medical equipment** for a high proportion of beneficiaries	Same issue; should be close to in-person care if hybrid practice; if only online practice, consider national averages and ensure appropriate documentation and referral patterns do not violate Start/Anti-trust

Billing, Coding and Documentaton

- If it isn't documented, it ain't done!
- Think about in-person care requirements for documentation
- Documentation for TeleHealth is no different than in-person care
- Coding is dependent on documentation
- No documentation, no coding
- Down charging
- Stethoscope, otoscope, eye exam, examination of the muscular system, neuro exam
- Denote Telehealth or Virtual Visit somewhere on your documentation

2 of 3 elements must be met or exceeded to meet MDM level.

Level of MDM	Number & Complexity of Problems Addressed at the Encounter	Amount & Complexity of Data to be Reviewed & Analyzed	Risk of Complications &/or Morbidity or Mortality of Patient Management
Straight-forward **99202** **99212**	**Minimal:** -1 self-limited or minor problem	**Minimal or none**	**Minimal risk** of morbidity from additional diagnostic testing or treatment
Low **99203** **99213**	**Low:** -2 or more self -limited or minor problems; **or** -1 stable chronic illness; **or** -1 acute uncomplicated illness or injury	**Limited**: ***Must meet at least 1 of the 2 categories*:** **Cat 1:Tests and documents** **Any combination of 2 from the following:** -Review of prior external note(s) from each unique source -Review of result(s) of each unique test -Ordering of each unique test **-or-** **Cat 2: Assessment requiring independent historian(s)**	**Low risk** of morbidity from additional diagnostic testing or treatment
Moderate **99204** **99214**	**Moderate:** -1 or more chronic illnesses w/exacerbation, progression, or side effects of treatment; **or** -2 or more stable chronic illnesses; **or** -1 undiagnosed new problem w/uncertain prognosis **or** -1 acute illness w/systemic symptoms; **or** -1 acute, complicated injury	**Moderate**: ***Must meet at least 1 of the 3 categories:*** **Cat 1: Tests, documents or independent historian(s)** **Any combination of 3 from the following:** -Review of prior external note(s) from each unique source -Review of result(s) of each unique test -Ordering of each unique test -Assessment requiring independent historian(s) **-or-** **Cat 2: Independent interp. of tests performed by another physician/other qualified health care professional -or-** **Cat 3: Discussion of management or test interpretation w/ external physician/other health care professional/appropriate source (not separately reported)**	**Moderate risk** of morbidity from additional diagnostic testing or treatment such as: Prescription drug management; Decision regarding minor surgery w/identified patient or procedure risk factors; Decision regarding elective major surgery without identified patient or procedure risk factors; Diagnosis or treatment significantly limited by social determinants of health
High **99205** **99215**	**High:** -1 or more chronic illnesses w/ severe exacerbation, progression or side effects of treatment; **or** -1 acute or chronic illness or injury that poses a threat to life or bodily function in the near term without treatment	**Extensive**: ***Same as Moderate except must meet 2 of the 3 categories.***	**High risk** or morbidity from additional diagnostic testing or treatment such as: Drug therapy requiring intensive monitoring for toxicity; Decision regarding elective major surgery w/identified patient or procedure risk factors; Decision regarding emergency major surgery; Decision regarding hospitalization; Decision not to resuscitate or to de-escalate care because of poor prognosis

Example MDM Level

Established patient with Leukemia in remission presents for clinic visit. The patient also has hypertension that is controlled with amlodipine and losartan. A CMP and CBC w/Diff and phosphorus level are obtained and the results are reviewed by the provider. The provider documents that patient is on NPTP as per week 28 TOT17 continuation. Treatment related pancytopenia. Counts slightly improved today at WBC 1.47 and ANC 1047. Will proceed with cyclo and ara-c with both doses reduced.
The medical decision making is calculated on the next slides.

2 of 3 elements must be met or exceeded to meet MDM level. The level of MDM for the visit below is Moderate.

Level of MDM	Number & Complexity of Problems Addressed at the Encounter	Amount & Complexity of Data to be Reviewed & Analyzed	Risk of Complications &/or Morbidity or Mortality of Patient Management
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Process for Reimbursement

- Develop a specific appointment type for TeleHealth/Telemedicine/e-visit/virtual visit
- Use standardized modifier on all claims (GT/95)
- Electronics comment “Services provided by TeleHealth”
- Ensure coding and billing teams understand rules and ‘catch’ and correct errors
- Properly vet outside billing vendors for Telehealth billing awareness
- Watch your reimbursement!

Thank You!