MONTANA HOSPITAL ASSOCIATION

Telehealth and Virtual Services Following the Pandemic

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Creating a Roadmap for the End of the COVID-19 Public Health Emergency

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"CMS encourages health care providers to prepare for the end of these flexibilities as soon as possible and to begin moving forward to reestablishing previous health and safety standards and billing practices."

Provider Fact Sheets

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- Physicians and Other Clinicians
- Hospitals and CAHs (including Swing Beds, DPUs) ASCs, and CMHCs
- Teaching Hospitals, Teaching Physicians and Medical Residents
- Long Term Care Facilities
- Home Health Agencies
- Hospice
- Inpatient Rehabilitation Facilities
- Long Term Care Hospitals & Extended Neoplastic Disease Care Hospitals
- Rural Health Clinics and Federally Qualified Health Centers
- Laboratories
- Medicare Shared Savings Program
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Medicare Advantage and Part D Plans
- Ambulances
- End Stage Renal Disease Facilities
- Participants in the Medicare Diabetes Prevention Program

https://www.cms.gov/coronavirus-waivers

Medicare Telehealth Coverage Pre-COVID-19

Section 1834(m)

1. **Geographic** - Patient must reside in rural area
2. **Location** - Patient must be physically present at healthcare facility when service is provided (facility fee)
3. **Service –** Coverage limited to CMS' list of approved telehealth services (CPT and HCPCS codes)
4. **Provider –** Service must be provided by physician, non-physician practitioner, clinical psychologist, clinical social worker, registered dietician, or nutrition professional
5. **Technology** - Must utilize telecommunications technology with audio ***and*** video capabilities that permits real-time interactive communication.

Medicare Coverage Pre-COVID-19

With Some Exceptions

- **Telestroke**
  - Effective 01/01/2019, geographic and location requirements do not apply to services furnished to diagnose, evaluate, or treat symptoms of acute stroke
- **Substance Use Disorder**
  - Effective 07/01/2019, geographic and location requirements do not apply to services relating to SUD and co-occurring behavioral health conditions
- **ESRD**
  - Effective 01/01/2019, geographic and location requirements do not apply to ESRD services relating to home dialysis
- **Medicare Advantage**
  - Beginning in 2020 plan year, MA plan may eliminate geographic and location requirements
- **Medicare Shared Savings Program**
  - Waiver of geographic and location requirements for ACO participants in risk models
- **CMMI Initiatives**

Medicare Telehealth Coverage Expansion

1. **Legislative Action**
   - Authorized Secretary to waive Section 1834(m) requirements for duration of PHE
2. **CMS Interim Final Rules**
   - Suspends certain *service* restrictions for duration of PHE
     - Expands list of covered services
     - Eliminates frequency requirements
     - Permits use of telehealth for required face-to-face visits, direct supervision for incident-to billing, teaching physician presence
   - Suspends certain *provider* restrictions for duration of COVID-19 PHE
     - Waives Medicare state licensure requirement (but not state law requirements)
     - Permits therapists and S/L pathologists to provide covered services via telehealth
     - Permits FQHCs and RHCs to bill for telehealth services under HCPCS G2025
     - Permits billing for hospital outpatient department and critical access hospital (Method 1 billing) services furnished via telehealth
   - Authorizes payment for certain audio-only E/M services (CPT 98966-68, 99441-43)
   - Provides reimbursement for telehealth services at higher non-facility rates to compensate practices for telehealth-associated costs

Medicare Telehealth Coverage Expansion

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3. Other Agencies' Actions

- Office of Civil Rights Notice of Enforcement Discretion - Will not impose penalties if, in good faith, use any non-public remote audio/visual communication product
- Office of Inspector General Notice of Enforcement Discretion– Permits waiver of co-insurance
- Drug Enforcement Administration – Use of telehealth for in-person medical evaluation prior to prescribing scheduled II – V controlled substances

Medicare Part B Telehealth Utilization

Year	Telehealth Eligible Users	Telehealth Users	Percentage of Medicare Users with a Telehealth Service
2020(Q1)	23,992,430	1,665,085	7%
2020(Q2)	21,985,392	10,262,251	47%
2020(Q3)	24,025,623	6,762,255	28%
2020(Q4)	23,859,999	6,633,028	28%
2021(Q1)	22,894,570	6,174,058	27%
2021(Q2)	23,390,837	4,306,696	18%
2021(Q3)	23,606,253	3,830,937	16%
2021(Q4)	23,545,483	3,725,184	16%
2022(Q1)	22,240,382	4,124,894	19%

https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-service-type-reports/medicare-telehealth-trends

Impact

- Telehealth follow-up was associated with lower 30- day readmissions than no timely post-discharge follow-up, but was associated with slightly higher 30-day readmissions than in-person follow-up.
  - CMS Data Highlight (January 2022) www.cms.gov/files/document/omh-data-highlight-2022-1.pdf

- Data suggests that telehealth expansions improved access to medication treatment and contributed to lower use of inpatient and/or emergency department visits among beneficiaries with OUD.
  - CMS Data Highlight (January 2022) www.cms.gov/files/document/data-highlight-jan-2022.pdf

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

- ~40% of Medicare beneficiaries used telehealth, 88 times more than prior year
- Identified 1,714 providers out of approximately 742,000 whose billing for telehealth services poses high risk to Medicare (2.3%)
  - Bills both a telehealth service and a facility fee for most visits
  - Bills telehealth services at highest level every time
  - Bills telehealth services for high number of days (300 days/year)
  - Bills both Medicare fee-for-service and MA plan for same service for high % of services
  - Bills high average number of hours of telehealth services per visit
  - Bills telehealth services for high number of beneficiaries
  - Bills telehealth service and orders DME for high % of beneficiaries

Tele-Behavioral Health

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- Consolidated Appropriations Act, 2021 – eliminate geographic and location restrictions for diagnosis, evaluation, and treatment of mental health disorder
- Must have in-person, non-telehealth service by practitioner in same practice as billing practitioner within 6 months prior to initial telehealth service + each 12 months thereafter
  - Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with reason documented in beneficiary's medical record)
- May use audio-only communication technology (vs. audio/video required for other telehealth services) but only if -
  - Practitioner has audio/video capability + beneficiary lacks capacity or refuses to use video connection
    - Documented in medical record + include service-level modifier on claim

Telehealth Flexibility Extensions

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Enacted March 15, 2022

- For 151 days post-PHE –
  - ✓ Continuation of waiver of geographic and location requirements
  - ✓ Continuation of reimbursement for therapist and S/L pathologist telehealth services
  - ✓ Continuation of reimbursement for audio-only services
  - ✓ Continuation of FQHCs and RHCs for telehealth services
  - ✓ Continuation of use of telehealth to recertify eligibility for hospice case
  - ✓ Delay in in-person requirement for initiation of tele-behavioral health services

Advancing Telehealth Beyond COVID-19 Act

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- Passed the House on July 27 by vote of 416-12
- Extend PHE telehealth coverage through December 31, 2024
- Now awaiting action by the Senate

2023 Medicare Physician Fee Schedule Proposed Rule

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1. Telehealth services list
2. Claims submission and payment
3. Direct supervision
4. Virtual services
5. RFI – Potentially underutilized high value services

1. Telehealth Services List

- Extend coverage for all services included on temporary basis for 151 days post-PHE (including those added after 3/15/22)
  - https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Identify those services included on temporary basis for which coverage **will not** be continued through 12/31/23 (Table 10)
  - Telephone E/M visit codes (CPT 99441-43)
  - Initial care (observation, hospital, nursing facility, domiciliary/rest home, home)
- Add new Category I codes
  - GXXX1-3 (prolonged inpatient, nursing facility, home/residence services by physician/NPP)

HCPCS	Short Descriptor
77427	Radiation tx management x5
92002	Eye exam new patient
92004	Eye exam new patient
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
93750	Interrogation vad in person
94002	Vent mgmt inpat init day
94003	Vent mgmt inpat subq day
94004	Vent mgmt nf per day
96125	Cognitive test by hc pro
99218	Initial observation care
99219	Initial observation care
99220	Initial observation care
99221	Initial hospital care
99222	Initial hospital care
99223	Initial hospital care
99234	Observ/hosp same date
99235	Observ/hosp same date
99236	Observ/hosp same date
99304	Nursing facility care init
99305	Nursing facility care init
99306	Nursing facility care init
99324	Domicil/r-home visit new pat
99325	Domicil/r-home visit new pat
99326	Domicil/r-home visit new pat
99327	Domicil/r-home visit new pat
99328	Domicil/r-home visit new pat
99341	Home visit new patient
99342	Home visit new patient
99343	Home visit new patient
99344	Home visit new patient
99345	Home visit new patient
99441	Phone e/m phys/qhp 5-10 min
99442	Phone e/m phys/qhp 11-20 min
99443	Phone e/m phys/qhp 21-30 min
99468	Neonate crit care initial
99471	Ped critical care initial
99475	Ped crit care age 2-5 init
99477	Init day hosp neonate care

2. Claims Submission and Payment

- Through Day 151 -
  - Will continue to pay non-facility rate for claims with modifier 95
  - Report POS code that would have been reported if service furnished face-to-face
- Day 152 and thereafter –
  - Discontinue modifier 95; use POS 02 (telehealth provided other than patient's home) or POS 10 (telehealth provided in patient's home)
  - Payment at lower facility rate ("We believe that the facility payment amount best reflects the practice expense, both direct and indirect, involved in furnishing services via telehealth")
  - Include modifier 93 for audio-only services (including RHCs, FQHCs, and OTPs)
- CMS will issue sub-regulatory guidance as needed to implement Telehealth Flexibilities Extension following end of PHE

3. Direct Supervision

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- Current status
  - Pre-PHE: Supervising physician/NPP physically present and immediately available to provide assistance
  - During PHE: Virtual presence using real-time audio/video technology
  - Post-PHE: Continue virtual presence through December 31 of year in which PHE ends; thereafter, revert to physical presence requirement
- CMS does not propose further extension of virtual supervision – “we continue to seek information on whether [virtual supervision] should potentially be made permanent” for some or all services

4. Virtual Services

- Scope
  - Care management (CCM, Complex CCM, PCM)
  - Remote monitoring (RPM and RTM)
  - Virtual (telephonic) check-ins (NOT telephonic E/M)
  - e-visits
- For duration of PHE -
  - May provide services for new and established patients
    - Still must obtain consent at initiation of services
  - May waive co-insurance (CMP enforcement discretion extends to these services)
  - For remote physiologic monitoring, only 2 days of data collection required for COVID-19 patients (vs. 16 days)

5. RFI – Potentially Underutilized High Value Services

We are seeking comments on ways to identify specific services and to recognize possible barriers to improved access to these kinds of high value, potentially underutilized services by Medicare beneficiaries. We are also seeking comment regarding how we might best mitigate some of these obstacles, including for example, through examining conditions of payment or payment rates for these services or by prioritizing beneficiary and provider education investments.

A Few Thoughts …

- Re-evaluation of practice expense RVUs (start-up costs, technology)
- Elimination of established patient, verbal consent requirements for virtual services
- Exercise of enforcement discretion under prohibition on beneficiary inducements for waivers of co-insurance
- Publication of definitive guidance on billing requirements (one stop shop)
- MIPS quality measure and performance improvement activities

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