Telemedicine and COVID-19

Increasing Revenue with Preventive Services Codes

How to Get Paid for Services You Are Already Proving

Presented by:

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ENOS Medical Coding

Disclosures

•Enos Medical Coding does not provide legal advice. The information in this presentation is based on the coding guidelines in the Current Procedural Terminology (CPT) Manual published by the American Medical Association (AMA) and Evaluation and Management Coding Guidelines from the Centers for Medicare and Medicaid (CMS)

About the Speaker

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Telehealth for the duration of the COVID-19 Public Health Emergency

Billing for remote visits

COVID-19 Regulatory Changes

- On March 17, 2020 the Centers for Medicare & Medicaid Services (CMS) issued guidance on Secretary Azar's waiver authority that broadens access to Medicare telehealth services.
- Effective March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, CMS will all qualified healthcare providers to care for patients remotely and bill Medicare and Medicaid, without meeting the existing requirements that will be covered in the following slides
- Check with other payers as their policies will likely change in accordance with CMS

Geographic Restrictions

- Patients can receive telehealth services in non-rural areas

- Under the “normal” rules,
  - a patient must be located in a rural area
  - The patient must be at a “qualified originating site” such as a hospital or healthcare facility
  - The visit is conducted by the facility with the performing physician in another location

Available to Patients in their home

- The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are in their homes or any setting of care.

Waiving communication restrictions

- A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients
  - The waiver allows use of telephones that have audio and video capabilities (smart phones)
  - Without video, use the telephone call CPT codes can be found in upcoming slides

Real-Time Communication

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home.
- Both the provider and the patient must be able to communicate using audio and video. ***Eg Facetime***
- Under this HHS Notice, however, Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers

Privacy Issues using FaceTime

- OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
- The HHS.gov Health Information Privacy Notice can be read by clicking here

HIPAA Compliance

- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies.
- Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules

Covered Health Care Provider Protection

- Providers that seek additional privacy protection for telehealth while using video communication products should provide such services through technology vendors that are HIPAA compliant and will enter into a HIPAA business Associate Agreement (BAA)
- Examples: Skype for Business, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet

Eligible Providers

- A range of providers, such as doctors, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, licensed clinical social workers, registered dietitians and nutrition professionals will be able to offer telehealth to their patients.
- Recognized, Licensed providers may vary, check your State regulations

Covered Codes

- Reimbursement will be allowed for any telehealth covered code* even if unrelated to treatment of a COVID-19 diagnosis, screen or treatment
- There are 101 CPT codes designated as eligible for telehealth payment.
  - Office or other outpatient visits
  - Subsequent hospital and nursing facility care visits
  - Psychotherapy
  - Health and behavioral assessment and interventions
  - End-stage renal disease services

Billing for Telehealth services

- Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

- Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

Copays can be waived

- The HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
  - The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

Patient Status

- The new rules do not enforce the established relationship requirement that a patient see a provider within the last three years.

- New Patients may be problematic when you have to document 3/3 elements (History, Exam and MDM) in order to bill a new patient code 99201-99205

- Documentation to support the level of service, or time, must be considered

Virtual Check-Ins

- Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

How is this different from virtual check-ins and e-visits?

- A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an inperson visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth.
- An e-visit is when a beneficiary communicates with their doctors through online patient portals.

Physician Telephone Services

- 99411 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***

- 99442 ***…. 11-20 minutes of medical discussion***

- 99443***…21-30 minutes of medical discussion***

- ***Summarize discussion and document time spent***

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Nonphysician Telephone Services

- 98966 Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment***; 5-10 minutes of medical discussion***

- 98967 …***11-20 minutes of medical discussion***

- 98968…2***1-30 minutes of discussion***

- ***Summarize the discussion and document time spent***

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Diagnosis Coding

- Conditions that will support medical necessity
- As always, your E/M codes must be supported by diagnosis codes that report symptoms or confirmed illness to establish the medical necessity of the service, and support the level of service
- For patients under your care for chronic conditions that must be assessed, this is straightforward
- For patients who have symptoms, just report the symptom codes

Diagnosis coding is allowed for all issues

- The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient.
- This is a critical point given the importance of social distancing and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely.
- For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

ICD-10 Coding for Coronavirus

- On January 30, 2020, the World Health Organization (WHO) declared the 2019 Novel Coronavirus (2019-nCoV) disease outbreak a public health emergency of international concern. As a result of the declaration, the WHO Family of International Classifications (WHOFIC) Network Classification and Statistics Advisory Committee (CSAC) convened an emergency meeting on January 31, 2020 to discuss the creation of a specific code for this new coronavirus.

- **U07.1, COVID-19 (test confirmed)**
- **Without a positive test**
  - Z71.84 Encounter for Health counseling related to Travel
  - Z71.1 Person with feared health complaint in whom no diagnosis is made

Documentation Requirements

- Understanding Documentation Guidelines and key components of E/M Services (History, Exam, Medical Decision Making; Time-based E/M Services; Documenting a billable visit example)

E & M Level of Service Breakdown

S Level of History

O Level of Exam

A P Level of Decision Making

Level of Service

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History

History of Present Illness

- Location, severity, timing, modifying factors, quality, duration, context, associated signs and symptoms
- 2 Levels
  - **Brief** 1-3 elements
  - **Extended** 4 elements or status of 3 chronic conditions

History

Review of Systems

- ❑ Constitutional
- ❑ Eyes
- ❑ Ears
- ❑ Cardiovascular
- ❑ Respiratory
- ❑ Gastrointestinal
- ❑ Musculoskeletal
- ❑ Integumentary
- ❑ Neurological
- ❑ Psychiatric
- ❑ Endocrine
- ❑ Hematological/Lymphatic
- ❑ Allergic/Immunology

- Both positive and negative patient answers must be documented in the HPI to be relevant
- 4 Levels:
  - **Problem Focused**: none
  - **Expanded Problem Focused**: Pertinent to Problem, 1 system
  - **Detailed**: 2-9 Systems, Extended
  - **Comprehensive**: Complete, 10 systems, ***or*** some systems with statement "all others negative"
  - Medicare carriers do include "all others negative" on their audit templates but have pulled back in allowing broad use of this phrase

History

Past, Family and/or Social History (PFSH)

- **Past History**
  Review of patient's past illnesses, operations, allergies, medications, details of pregnancy or birth, etc.
- **Family History**
  Review of patient's parents/siblings medical events, diseases, health status, cause of death, or hereditary conditions that may place the patient at risk.
- **Social History**
  Review of social factors, school/daycare settings, smoking, alcohol/drug use, occupation that may impact the patient's health.

History

To select the level, all elements must be met

History of Present Illness (HPI)	Review of Systems (ROS)	Past, Family, and/or Social History (PFSH)	Level of History
Brief (1-3 elements)	No ROS	No PFSH	**Problem Focused**
Brief (1-3 elements)	Problem Pertinent (1 system)	No PFSH	**Expanded Problem Focused**
Extended (4 or more)	Extended (2-9 systems)	Pertinent (1 history)	**Detailed**
Extended (4 or more)	Complete (10 or more)	Complete (2-3 history areas)	**Comprehensive**

Documentation

- A
  - Assessment
  - Number of Diagnoses (must be specific)
  - Complexity and Amount of Reviewed Data
- P
  - Treatment Plan Options
  - Risk of Complications

Medical Decision Making

Medical decision making is determined by considering the following factors:

- The number of diagnoses and/or management options that must be considered;
- The amount and/or complexity of data that must be obtained, reviewed, and analyzed;
- The risk of significant complications, morbidity, and/or mortality associated with the patient's presenting problem(s), or management options.

Medical Decision Making

A **Presenting Problems to the Treating Provider** (# Diags Require Active Management **or Affect Treatment Options**)			
	Points = Result		
Self limited / minor (stable, improved or worse)	Max = 2	**1**	
Est. problem (stable, improved)		**1**	
Est. problem (worsening)		**2**	
New problem (to Provider) (no add'l workup)	Max=1	**3**	
New problem (to Provider) (additional workup)		**4**	
Bring total to Line A in Final Result for Complexity **TOTAL**			

New vs. Self limited problem: If the problem warrants the initiation of a new treatment plan *(ie: prescription drug management, additional diagnostic workup, referral to a specialist, over the counter medications with provider follow up if needed, etc),* it's new. If the problem does not warrant the creation of a treatment plan, it's self limited/minor

Medical Decision Making

B	Amount **and/or** Complexity of Data to be Reviewed	**Pts.**
	Review or order of clinical lab tests	1
	Review or order of tests in the radiology section of CPT	1
	Review or order of tests in the medicine section of CPT	1
	Discussion of test results with performing physician	1
	Decide **to obtain** old records or **to obtain** history from someone else	1
	Review & summarize old records **or get Hx** from someone **or** talk with **other provider**	2
	Independent visualization of image, tracing or specimen itself (not simply review of the paper copy report)	2
	Bring total to Line B in Final Result for Complexity **TOTAL**	

Level	Presenting Problem(s)	Management Options Selected
Minimal	• One self-limited or minor problem (cold, insect bite, tinea corporis) [i.e. runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status]	• Rest • Gargles • Elastic bandages • Superficial dressings
Low	• Two or more self-limited or minor problems • One stable chronic illness (well controlled hypertension, stable diabetes, cataract, BPH) • Acute uncomplicated illness or injury (cystitis, allergic rhinitis, simple sprain)	• Over the counter drugs, or renewal of long-term medications, w/o history of adverse side effects • Minor surgery w/ no identified risk factors • Physical therapy • Occupational therapy • IV fluids w/o additives
Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (lump in the breast) • Acute illness with systemic symptoms (pyelonephritis, pneumonitis, colitis) • Acute complicated injury (head injury w/ brief loss of consciousness)	• Minor surgery with identified risk factors • Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors • Prescription drug management such as writing a new script, renewing recently prescribed drugs, adjusting dosages, or discontinuing medications • Therapeutic nuclear medicine • IV fluids with additives • Closed treatment of fracture or dislocation w/o manipulation
High	• One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment • Acute or chronic illness or injury that may pose a threat to life or bodily function (multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness w/ potential threat to self or others, peritonitis, acute renal failure, etc) • An abrupt change in neurologic status (seizure, TIA, weakness, sensory loss)	• Elective major surgery (open, percutaneous, or endoscopic) with identified risk factor • Emergency major surgery • Parenteral controlled substances • Drug therapy requiring intensive monitoring for toxicity • Decision not to resuscitate or to de-escalate care because of poor prognosis

Medical Decision Making

The table below shows the elements for each level of medical decision making. Note that to qualify for a given level of medical decision making complexity, **two of the three** elements must be either met or exceeded.

# of dx or mgmt options	Amt and/or complexity of data	Risk of Complications	Type of Decision Making
Minimal (≤1)	Minimal (≤1)	Minimal	**Straightforward**
Limited (2)	Limited (2)	Low	**Low complexity**
Multiple (3)	Moderate (3)	Moderate	**Moderate complexity**
Extensive (≥4)	Extensive (≥4)	High	**High complexity**

Counseling and/or Coordination of Care

- Whenever counseling and/or coordination of care dominates (more than 50% of) the encounter, time is considered the ***key or controlling factor*** to qualify for a particular level of E/M service.
- If the level of service is reported based on time spent counseling and/or coordinating of care, the documentation must show:
  - ❖The total length of the encounter
  - ❖That greater than 50% of the time was spent counseling
  - ❖The content of the counseling or coordination of care

TIME

- For coding purposes, face-to-face time for office visits is defined as only that time that the physician spends face-to-face with the patient and/or family.
- Now, ***Face-to-Face time*** can mean "***FaceTime***"
- This is in line with the 2021 changes to E/M level selection for office visits, where the time may be used for level section, and the time includes the total time on the date of the encounter and includes face-to-face and non-face-to-face time spent personally by the provider.

New Office Patient

Required Components: 3/3

E/M	Hx	Exam	MDM	Time
99201	PF	PF	SF	10
99202	EPF	EPF	SF	20
99203	Detailed	Detailed	Low	30
99204	Comp	Comp	Moderate	45
99205	Comp	Comp	High	60

Established Office Patient

Required Components: 2/3

E/M	Hx	Exam	MDM	Time
99212	PF	PF	SF	10
99213	EPF	EPF	Low	15
99214	Detailed	Detailed	Moderate	25
99215	Comp	Comp	High	40

Telehealth Modifiers

- CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers.
- However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims:
  1. In cases when a telehealth service is furnished via **asynchronous** (*store and forward*) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the **GQ modifier** is required.
  2. When a telehealth service is billed under **CAH Method II**, the **GT modifier** is required.
  3. When telehealth service is furnished for purposes of diagnosis and treatment of an **acute stroke**, the **G0 modifier** is required.

Telehealth Modifiers

- Check with payers to verify their requirements for modifiers

Code	Service description
Modifiers	
GT	Via interactive audio and video telecommunication systems
95	Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system
G0	Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke

State Medicaid Programs

- States have broad flexibility to cover telehealth through Medicaid.
- No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.
- A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

Key Takeaways

- *Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.*
- *These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.*
- *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.*

Key Takeaways

- *While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.*

Key Takeaways

- *The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.*
- *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.*

Back to our Original Program…

Group Visits

SHARED MEDICAL APPOINTMENTS

Shared Medical Appointments

- Shared or Group Visits are beneficial to your patients as an alternate method of scheduling patients with same, often chronic, conditions.
- By seeing the patients as a group, providers can:
  - Save time
  - Devote more time to patient education
  - Create a highly supportive admosphere
  - Provide extensive resources such as guest speakers

Shared Medical Appointments

- In order to bill a typical E/M code, the key components must be met, and documented
  - At the end of the session, the provider sees each patient individually to discuss specific problems
  - Notes should include chief complaint, HPI, Objective exam such as patient's vitals, review blood and other tests performed or ordered
  - Summarize the time and content of counseling

Compliance Issues

- No official payment or coding rules have been published by Medicare
- However, many practices bill based on the most appropriate CPT code when billing for a documented face-to-face service.
- Select the code based on the appropriate place of service, and level of service
- For example, office 99212-99214

Documentation Requirements

- History
  - Chief complaint, History of Present Illness (HPI) Review of Systems (ROS) Pertinent Past, Family and Social History (PFSH) such as medications.
  - Exam
    - Vital Signs
  - Assessment and Plan
    - Summarize the diagnosis, content of discussion, recap the treatment plan and follow up instructions

Alternate types of Codes

- If group visits include the services of nutritionists or a behavioral health specialist, use the appropriate codes
  - Medical Nutrition Therapy 97804
  - Health and Behavior intervention 96153
  - Physician education in a group 99078
    - May not be covered under all contracts
- 98961: Group education and training, 2-4 patients, each 30 min.
- 98962: Group education and training, 5-8 patients, each 30 min

Billing Considerations

- If you bill a CPT code that requires a copay such as an office E/M, you will be required to collect the copay from each patient
- If a Nurse Practitioner or Physician is providing the face-to-face service you can bill E/M at 99213 or higher based on complexity
- If a nutritionist or other ancillary provider conducts the group session, bill based on their level of enrollment (do not bill under the physician)

Nurse Visits 99211

- According to the CPT manual, a 99211 is an office or other outpatient visit "that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services."
- Unlike the rest of the office visit codes, 99211 does not have any documentation requirements for the history, physical exam or complexity of medical decision making. The nature of the presenting problem need be only "minimal," such as monthly B-12 injections, suture removal, dressing changes, allergy injections with observation by a nurse, and peak flow meter instruction.
- Do not use for “shot visits” the administration codes include the work of 99211.
- Remember, if you bill a 99211 you must collect a copay.

Preventive Services

Preventative Medicine

- **Codes are based on New vs. Established**
- **New and Established Patient**
- Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

  An established patient is one who has received professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

  In the instance where a physician is on call for or covering for another physician, the patient's encounter will be classified as it would have been by the physician who is not available.

Preventative Medicine Issues

- The extent and focus of the service will vary based on the age of the patient

- If an abnormality/ies is encountered or a preexisting problem is addressed in the process of performing this preventive medicine evaluation and management service, **and if** the problem/abnormality is *significant enough* to require additional work to perform the key components of a problem-oriented E/M service, then the appropriate Office/Outpatient code 99201-99215 should also be reported.

Preventative Medicine Issues

- **Combination visits:**
- Modifier 25 should be added to the Office/ Outpatient code to indicate that a significant, separately identifiable Evaluation and Management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service is additionally reported.
- An insignificant or trivial problem or abnormality that is encountered in the process of performing the preventive medicine evaluation and management service and which does not require additional work and the performance of the key components of a problem-oriented E/M service, should not be reported.

Counseling/Risk Factor

- 99401 (weight management)- 15 minutes
  - Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual without a specific illness for which the counseling might otherwise be part of a treatment
- 99402- 30 minutes
- 99403- 45 minutes
- 99404- 60 minutes
  - Preventive medicine individual counseling services are face-to-face services performed by a physician or other qualified health care provider in order to foster healthy living and/or avert illness/injury. Risk factor counseling may be utilized in the absence of illness

Behavior Change/Interventions

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
  - 99407 greater than 10 minutes
- 99408 Alcohol and/or substance (other than tobacco) abuse structured screening (eg, AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
  - 99409 greater than 30 minutes

Diabetes self management training

- G0108 Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109 Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
- These codes are for diabetes self-management training services, either individually or in a group of two or more. Diabetes self-management training is done to teach the diabetic how to control and monitor blood glucose levels with the proper use of the monitoring device, dietary calculations and restrictions, and correct administration of diabetic medications. These codes are reported per **30** minute intervals.

Who may furnish the training

- The person or entity must furnish other services for which direct Medicare payment may be made and must otherwise be **eligible** to receive Medicare payments under Medicare's rules governing assignment and reassignment of benefits.
- The person or entity must be **accredited in diabetes educ**ation, meaning the person or entity has met a set of quality standards approved by CMS. These can be CMS's own standards, the National Standards for Diabetes Self-Management Education Programs or the standards of a "national accreditation organization that represents individuals with diabetes" (e.g., the American Diabetes Association).
- Individuals or entities must submit **proof of their accreditation** to CMS. They must also agree to submit to HCFA validation of the accrediting organization's process and authorize the accrediting organization to release to HCFA a copy of their most recent accreditation evaluation, plus any other accreditation-related information that HCFA may require.
- The person or entity providing the training must also provide to **CMS documentation** such as diabetes outcomes measurements, as requested.
- The individual or entity must allow the area peer review organization to access beneficiary or group training records.

Who qualified for the coverage?

- New-onset diabetes;
- Inadequate glycemic control (i.e., an HbA_{1C} level of 8.5 or more on two consecutive determinations at least three months apart);
- Change in treatment either from no diabetes medication to any diabetes medication or from oral diabetes medication to insulin;
- High risk for complications based on inadequate glycemic control (i.e., documented acute episodes of severe hypoglycemia or severe hyperglycemia requiring ER visits or hospitalization);
- High risk for at least one of the following documented complications: lack of feeling in the foot or other foot complications (e.g., ulcers); pre-proliferative retinopathy or prior laser treatment of the eye; or kidney complications manifested by albuminuria or elevated creatinine.

Types and Frequency

- Medicare covers two types of training. One is **initial training**. It must be furnished within a continuous 12-month period and may not exceed a total of 10 hours. Of that 10 hours, nine should be furnished in a group setting consisting of two to 20 individuals (not all of whom have to be Medicare beneficiaries), and one hour may be an individual session to assess the beneficiary's training needs. The training must be furnished in increments of no less than one-half hour.

Types and Frequency

- Medicare also covers **follow-up training** as long as it begins at least one calendar year following the beneficiary's initial training. Follow-up training may not exceed two hours of individual or group training per year for a beneficiary, and it must be furnished in increments of no less than one-half hour. Finally, the physician must document the specific medical condition that the follow-up training must address in both the referral for training and the beneficiary's medical record.

Behavioral Counseling for Obesity

Intensive Behavior Therapy for Obesity

- G0447 Face-to-face behavioral counseling for obesity, 15 minutes

Five A's Approach

- Assess: behavioral health risk(s) and factors
- Advise: give clear, specific and personalized advice
- Agree: collaborate on selected treatment goals/method
- Assist: using behavioral change techniques, aid the patient in achieving goals by acquiring the skills, confidence and support
- Arrange: schedule follow up contacts to provide ongoing assistance/support and to adjust plan as necessary

CMS covers:

- One face-to-face visit every week for the first month;
- One face-to-face visit every other week for months 2-6;
- One face-to-face visit every month for months 7-12, if the beneficiary meets the 3kg weight loss requirement as discussed below.

- At the six month visit, a reassessment of obesity and a determination of the amount of weight loss must be performed.
- To be eligible for additional face-to-face visits occurring once a month for an additional six months, beneficiaries must have achieved a reduction in weight of at least 3kg over the course of the first six months of intensive therapy.
- This determination must be documented in the physician office records for applicable beneficiaries consistent with usual practice.
- For beneficiaries who do not achieve a weight loss of at least 3kg during the first six months of intensive therapy, a reassessment of their readiness to change and BMI is appropriate after an additional six month period

Billing “Incident to”

Billing for Non-Physician Practitioners

- Check with payers to see if you can credential Non-Physician Practitioners, such as dieticians, NP, PA's under the billing name/number of the supervising physician
- If not, are you allowed to bill under the supervising physician for all visits
- If they do enroll NPP's can you bill under the physician if the service is "incident to" the physician

Incident to Rule

- The “services or supplies are furnished as an integral, although incidental, part of the physician's services in the course of diagnosis or treatment of an injury or illness.”
  - This means the physician has included the services as part of the plan of care, and has established a diagnosis and course of care.
  - Non-Physicians cannot bill Medicare for new patients or for established patients with new problems. There must be frequent and subsequent services to reflect continuing, active management of the treatment.

Incident to Rule

- The **physician's office or clinic** must commonly furnish the type of services being billed as incident to.
- Physicians shouldn't bill for incident to services performed in an inpatient or outpatient hospital setting, and services performed during home visits or in nursing homes should only be billed if the physician is physically present.

Incident to Rule

- The physician must always provide **direct personal supervision** for the services to meet requirements. If a nonphysician practitioner.
- NPP performs services in an office setting, the supervising physician must be present in the office suite and immediately available to direct the NPP if necessary.

Incident to Rule

- The NPP must be an **employee** of the physician or group practice. He or she may be a full-time, part-time, contracted or leased employee of the supervising physician, or physician group practice.
- The NPP may also be a staff member of the legal entity that employs the physician who provides direct personal supervision

Medicare Screening Services

- The Patient Protection and Affordable Care Act (PPACA) changed coverage of preventative care services to Medicare
- Since January 1, 2011, CMS covered Annual Wellness Visits for Medicare Beneficiaries
- Other screening services may be covered based on frequency and patient risk
- Check Medicare's billing guide for G-Codes to report screening procedures and V-codes allowed as diagnoses
- http://www.medicarenhic.com/providers/pubs/REF-EDO-0002_Preventive_Services_Billing_Guide.pdf

Medicare Covered Screening Services

- Bone Mass Measurement
- **Cardiovascular Screening**
- Colorectal Cancer Screening
- **Diabetes Screening**
- Flu (Influenza) Injections
- Glaucoma Screening
- Hepatitis B Injections
- Initial Preventive Physical Examination
- Mammography Screening
- **Medical Nutrition Therapy**
- Pneumococcal Pneumonia Vaccination (PPV)
- Prostate Cancer Screening
- Screening Pap Smears
- Screening Pelvic Examinations
- Smoking and Tobacco-Use Cessation
- Ultrasound Screening for Abdominal Aortic Aneurysm

Screening Codes

- Hearing
  - 92560 Bekesy Audiometry
  - 92551 pure tone, air only
- Vision
  - 99173 Visual acuity, quantitative, bilateral
- Pap Smears
  - 88150 screening
  - 88153 rescreening
  - 88147 automated screening

- Hearing
  - V5008 Hearing Screening
- Behavioral Health
  - G0444 Annual depression screening, 15 minutes
  - G0442 Annual alcohol misuse screening, 15 minutes
- Prostate
  - G0102 Prostate cancer screening, digital rectal examination
- Breast and Pelvic
  - G0101 Cervical or vaginal cancer screening, pelvic and clinical breast examination

Advanced Beneficiary Notice (ABN) Requirements

- A physician should obtain an Advanced Beneficiary Notice (ABN) when services provided fall outside of Medicare coverage requirements. The ABN can be found on the CMS website at: http://www.cms.gov/cmsforms/downloads/cmsr-131-g.pdf.
- Physicians, practitioners and hospitals will be liable for screening services unless they issue an appropriate Advanced Beneficiary Notice

Medical Nutrition Therapy

Medical Nutrition Therapy

- Physicians and other Qualified Health Care professionals who may report evaluation and management services should use the appropriate evaluation and management codes

- A **dietetic professional** provides medical nutrition therapy assessment or re-assessment and intervention in a face-to-face or group patient setting. After nutritional screening identifies patients at risk, preventive or therapeutic dietary therapy is initiated to induce a positive result in the role nutrition plays in improving health outcomes

CPT Codes

- 97802 Medical nutrition therapy; *initial assessment* and intervention, individual, face-to-face with the patient, each 15 minutes ($35.17)*
- 97803 Medical nutrition therapy; *re-assessment and intervention*, individual, face-to-face with the patient, each 15 minutes ($30.51)*
- 97804 Medical nutrition therapy; *group* (2 or more individual(s)), each 30 minutes ($16.15)*

- **from the 2017 National Medicare Fee schedule*

Medicare G Codes

- G0270-Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes ($30.60)
- G0271- Medical nutrition therapy, reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes ($16.20)

Compliance and Billing

Lifestyle Coding and Billing Objectives

- **When is a Lifestyle Medicine visit billable to insurance?**
- **Understanding conditions that will support medical necessity**
- **Understanding Documentation Guidelines and key components of E/M Services**
  - **History, Exam, Medical Decision Making**
  - **Time-based E/M Services**
  - **Clinical example- documenting a billable visit**
- **Understanding coding guidelines and identify risk areas for E/M services with:**
  - Patient Status
  - Billing for Time Spent Counseling
  - Obesity Counseling
  - E/M Modifiers

Understand "Incident to" billing rules for mid-level providers

ENOS Medical Coding

When is a visit billable to insurance?

- Determining if a service is covered depends on:
- The patient's insurance plan
- The practices "participation" with the plan
- ***Medical necessity*** of the service
- Coverage limitations for preventive services

Medical Necessity

- Evaluation and Management services must be medically necessary and supported by a chief complaint, assessment and plan that show the need for the service
- Conditions such as:
  - Diabetes and Prediabetes
  - Obesity
  - Metabolic Syndrome
  - Lipid Disorders
  - Sarcopenia

Insurance Coverage Issues

- Insurance plans vary on the range of services covered by a patient's policy
- High deductibles, copays, co-insurance should be verified before providing a service
- Medical Necessity is key
- Preventive services are often covered but research your contacted payers for their reimbursement policies

Self Pay Issues

- Many patients have a Health Savings Account (HAS)
  - Pre-tax employee contributions
  - Employer contributions
- Plan rules may limit types of expenses
- IRS rules apply

- **Qualified medical expenses.**
- Qualified medical expenses are those specified in the plan that generally would qualify for the medical and dental expenses deduction. These are explained in Pub. 502.
- Also, non-prescription medicines (other than insulin) aren't considered qualified medical expenses for FSA purposes.
- A medicine or drug will be a qualified medical expense for FSA purposes *only if the medicine or drug:*
  - Requires a prescription,
  - **Is available without a prescription (an over-the-counter medicine or drug) and you get a prescription for it, or Is insulin**.

Compliance Issues

- Provider Enrollment varies by payer
- Be sure to identify the “service provider” and the “billing provider”
- If the “service provider” is not the “billing provider” is the service allowed under “Incident to” rules?
- Does the insurance company enroll Non-Physician Providers?

References

- **CMS Medicare Telemedicine Health Care Provider Fact Sheet can be found here**
- **Medicare Telehealth FAQs click here**
- **CMS Evaluation and Management Guide click here**
- **CMS Notice for discretion for telehealth click here**

Appendix

Telehealth Educational Materials which may be useful AFTER the emergency measures expire

What is Telehealth?

- There are many new medical tech terms being used today that the average patient may not be familiar with. For example, **a common misunderstanding** is that the terms telemedicine, telecare, and telehealth are interchangeable.
- The truth is that each of these terms refers to a different way of administering health care via existing technologies or a different area of medical technology. To clarify the **subtle differences between these three terms**, we have provided a detailed definition of each.
-

Telehealth

- According to CMS, telehealth services must be provided via an interactive audio and video telecommunications system that allows for real-time communication between the provider and the beneficiary. The exceptions are Alaska and Hawaii, where asynchronous technology — defined as the transmission of medical information to the distant site and reviewed later by the physician or practitioner — is permitted in federal telemedicine demonstration programs.
- Telehealth technology enables the remote diagnoses and evaluation of patients in addition to the ability to remote detection of fluctuations in the medical condition of the patient at home so that the medications or the specific therapy can be altered accordingly. It also allows for e-prescribe medications and remotely prescribed treatments.

Telehealth Sites

- The originating site is where the patient is at the time of the telehealth encounter
- Examples are hospitals, rural health clinics, FQHCs, skilled nursing facilities and community mental health centers
- The distant site is where the provider delivering the service is located. These providers include:
  - Physicians, Nurse Practitioners, Physician Assistants, Clinical Nurse specialists, Clinical psychologists and clinical social workers, registered dieticians or nutritionists

Online digital evaluation and management

Code	Average Payment	Description
99421	$13.35	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	$27.43	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99423	$43.67	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Online digital evaluation and management

INCLUDES

Cumulative service time within a 7 day time frame needed to evaluate, assess, and manage the patient:

- Ordering of tests
- Prescription generation
- Separate digital inquiry for new and unrelated problem
- Subsequent communication that is digitally supported (i.e., email, online, telephone)

Digital service initiated by an established patient

EXCLUDES

Clinical staff time

*Digital evaluation by a qualified nonphysician health care professional (**98970**-**98972**)*

Digital evaluation peformed with separately reportable E&M services during same time frame for new or established patient:

- *Inquiries related to previously completed procedure and within the postoperative period*
- *INR monitoring (**93792**-**93793**)*
- *Office consultation (**99241**-**99245**)*
- *Office or other outpatient visit (**99201**-**99205**, **99212**-**99215**)*
- *Patient management services (**99339**-**99340**, **99374**-**99380**, [**99091**], **99487**-**99489**, **99495**-**99496**)*

Digital service less than 5 minutes

Use of code more than one time in 7 days

Documentation requirements

- Documentation requirements for a telehealth service are the same as for a face-to-face encounter. The information of the visit, the history, review of systems, consultative notes or any information used to make a medical decision about the patient should be documented. Best practice suggests that documentation should also include a statement that the service was provided through telehealth, both the location of the patient and the provider and the names and roles of any other persons participating in the telehealth service.

  It is advisable to follow local Medicare Administrative Contractor (MAC) guidance for final instructions on billing and documentation requirements for telehealth services. Additionally, private payers may follow the guidelines set forth by Medicare or may have their own.

  As telehealth becomes more efficient and improves patient outcomes, more services are likely to be approved for reimbursement. As more payers cover telehealth services, payment policies and criteria will change, so keep a watchful eye on the situation.

What is Telemedicine?

- Telemedicine is the practice of medicine using technology to deliver care at a distance. A physician in one location uses a telecommunications infrastructure to deliver care to a patient at a distant site.
- As long as the physician performs and documents the elements of history, exam and decision making (or time counseling) and document them the same as you would in person – and meet the conditions of a telemedicine visit- then you can bill and E/M visit

Medicare Requirements

- Although ND's may not participate with Medicare, may payers follow Medicare rules, so they are worth discussing
- Medicare requires the GT modifier and
- The patient must be in a HPSA (healthcare professional shortage area)
- Medicaid may or may not pay
- Most commercial insurance accepts the 95 modifier

Telehealth example

- A Medicare patient presents to a rural health clinic complaining of a headache, nausea and vomiting. A clinical staff employee at the originating site escorts the patient to a room where the patient can interact with the provider using audiovisual equipment. The provider performs the necessary history, and a clinical staff employee obtains the clinical information, such as vital signs, requested by the provider.

  If the clinic has the appropriate equipment and personnel, diagnostic tests ordered by the provider are performed onsite. The provider renders the patient assessment and plan to be discussed with the patient. During this new patient encounter, the provider performs and documents a detailed history, an expanded problem-focused exam and moderate medical decision-making. Also included in the documentation is information stating that the service was provided through telehealth, the location of the patient and the provider, and the names of any other staff involved in the service.

  For the distant site in this example, CPT code 99202 is billed with POS code 02 for the professional provider's service. The originating site should report HCPCS code Q3014 for the services provided.

Telemedicine Codes

- The **codes** 99201-99205, 99211 - 99215, the consultation **codes** 99241-9945 and others can be reported with the **telemedicine** modifiers QT or 95 depending on the payer.

- The American Academy of Family Physicians has an article on their website that discusses Telemedicine Reimbursement and Licensure
- https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/BKG-Telemedicine.pdf

2019 (new) Telemedicine CPT Codes

- G2010 Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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
- Physicians or other qualified practitioners review photos or video information submitted by the patient to determine if a visit is required. The service may be provided to an established patient when a related evaluation and management (E/M) service has not been provided in the previous seven days and may not lead to an E/M service within the next 24 hours or soonest available appointment.

2019 (new) Telemedicine CPT Codes

- G2012 Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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. Avg payment $13.35
- A physician or other qualified health care professional conducts a virtual check-in, lasting five to ten minutes, for an established patient using a telephone or other telecommunication device to determine whether an office visit or other service is needed. The service may be provided when a related evaluation and management (E/M) service has not been provided in the previous seven days and it may not lead to an E/M service within the next **24** hours or soonest available appointment.

CPT Assistant - Coronavirus

Question: *Should CPT code* 87635*, a HCPCS Level II code, or both be reported if the test for COVID-19 is performed?*

Answer: The appropriate code to be reported is dependent upon the payer to which the claim is being submitted. If the claim is submitted to a payer that requires CPT codes, then code 87635 should be reported. Conversely, if the payer requires use of the HCPCS Level II code, the HCPCS Level II code should be reported. CPT and HCPCS codes should not both be reported on the same claim. Contact your local third-party payer directly to determine their specific reporting guidelines.

CPT Assistant - Coronavirus

Question: *Codes already exist in the Pathology and Laboratory section of the CPT code set for coronavirus. What is the difference between the new code* 87635 *and the other CPT codes that state coronavirus in their descriptor (ie, 87631, 87632, 87633, 0098U, 0099U, 0100U)?*

Answer: *Existing codes 87631, 87632, and 87633 are used for nucleic acid assays that detect multiple respiratory viruses in a multiplex reaction (ie, single procedure with multiple results). Similarly, proprietary laboratory analyses (PLA) codes 0098U, 0099U, and 0100U are used to identify multiple types or subtypes of respiratory pathogens. In contrast, code* 87635 *is for the detection of SARS-CoV-2 (COVID-19) and any pan-coronavirus types or subtypes, and it can be reported with tests from multiple manufacturers using the stated technique.*

CPT Assistant - Coronavirus

Description of Procedure (87635)

Place specimens (eg, nasopharyngeal or oropharyngeal swab, sputum, lower respiratory tract aspirate, bronchoalveolar lavage, and nasopharyngeal wash or aspirate or nasal aspirate) into specimen-transport containers. Use oligo-nucleotide primers and probes for detection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (formally known as 2019-nCoV), and any pan-coronavirus types or subtypes if included, to identify viral gene target(s). Isolate and purify ribonucleic acid (RNA) from the specimens, followed by molecular amplification and analysis. Send the test result (positive, negative, inconclusive) to the patient's physician or other QHP and report or refer to the appropriate public health officials, as indicated.

Resources:

- http://coronavirus.gov/ - The CDC site devoted to COVID-19 information, updates, information for providers, community resources, and frequently asked questions.
- https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet - CMS fact sheet announcing expansion of telehealth services on March 17th.
- https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth - Health Information Privacy Notice
- Frequently Asked Questions – FAQ posted by CMS
- https://www.ama-assn.org/system/files/2020-03/cpt-assistant-guide-coronavirus.pdf - Special (**FREE**) edition of CPT Assistant with guidance on the new CPT code

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