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With Telehealth on OIG Work Plan, Beware Pitfalls; CMS Proposes HHA Telehealth Past PHE

By Nina Youngstrom

When a physician's telehealth visit with a Medicare patient on FaceTime cut out after five minutes, they shifted to an audio-only visit, with the physician and patient speaking on the telephone. Although the call lasted for an hour, the physician didn't document the time. That put her in a bind. To bill a time-based evaluation and management (E/M) service, such as a phone call, providers have to document the total time. They can only use medical decision-making to support office visit codes when the audio and visual components are live for the majority of the encounter.

"Defaulting to the telephone-only visits (99441–99443), which were opened up for reimbursement a month into the COVID-19 public health emergency, must be based on time," said Terry Fletcher, a consultant in Laguna Beach, California. "Without time documented, this encounter has no value to bill to a payer."

That's a potential "downfall" of telehealth reimbursement, Fletcher said. Providers also will "tap out" at 21 minutes with the telephone codes, she noted. These are things to keep an eye on, especially now that the HHS Office of Inspector General has added Medicare telehealth services during the COVID-19 pandemic to its Work Plan.[1]

Telehealth continues to be a focal point during the COVID-19 public health emergency (PHE), as providers parse billing nuances, adapt to new developments and worry what the future holds. CMS already embraced permanent changes to telehealth in its proposed 2021 home health prospective payment system regulation,[2] which was published in the June 30 *Federal Register*, and is poised to broaden the telehealth benefit generally beyond the PHE in the 2021 Medicare Physician Fee Schedule, which is due out any minute. There's also momentum in Congress to improve access to telehealth services. Most pending bills address the originating site requirement, which limits Medicare coverage of telehealth to services provided at hospitals and other providers in rural areas, said attorney T.J. Ferrante, with Foley & Lardner in Tampa, Florida. "If I were a gambler, that's what I would bet they would change," he said. Congress suspended the originating site requirement during the PHE, which expires July 25, although Michael Caputo, HHS assistant secretary for public affairs, has tweeted that it would be extended another 90 days. HHS Sec. Alex Azar still has to make it official, and even when that happens, he has the option to revoke the PHE early, without giving providers notice, Ferrante said. The same goes for President Trump and his Jan. 31 declaration of a national emergency, which is supposed to last for one year. "It leads to uncertainty," Ferrante said.

While both the PHE and the national emergency are required to continue with Sec. 1135 waivers, most aspects of telehealth expansion fall outside the Sec. 1135 process, said Chicago attorney Sandra DiVarco, with McDermott Will & Emery. Because most of the telehealth flexibilities, including those related to the originating site, are the result of the Coronavirus Aid, Relief, and Economic Security Act[3] and not the waivers, they will continue even if the national emergency is revoked or expires, she said.

When Visual Fails, Which Medium Do You Bill?

Because the ramping up of telehealth services happened so fast and may continue permanently, the stakes are high for providers to comply with billing and documentation requirements. Some of the same telehealth questions keep coming up on CMS's weekly stakeholder engagement calls. The audiovisual to telephone-only services is a biggie.

When the technology changes, providers should bill the medium that is used for 50% or more of the visit, said Marion Salwin, director of physician and regulatory compliance at Trinity Health in Livonia, Michigan. "I have heard more than one person say the code is based on the intent [of the visit]," but that's not true. CMS has clarified and elaborated in answers to frequently asked questions[4] on its website, although it has declined to give a specific percentage:

> Question: If the video connection is disconnected during an audio-video Medicare telehealth visit due to technological issues, can the visit still be billed as Medicare telehealth?
>
> Answer: Practitioners should report the code that best describes the service. If the service was furnished primarily through an audio-only connection, practitioners should consider whether the telephone evaluation and management or assessment and management codes best describe the service, or whether the service is best described by one of the behavioral health and education codes for which we have waived the video requirement during the PHE for the COVID-19 pandemic. If the service was furnished primarily using audio-video technology, then the practitioner should bill the appropriate code from the Medicare telehealth list that describes the service…

No Need to Document Exam

Only physicians and certain qualified health professionals (QHPs) (i.e., nurse practitioners and physician assistants) are permitted to bill CPT codes 99441–99443, Fletcher said. All is not lost, however. Medicare will pay for audio-only telehealth services provided by other QHPs (e.g., certain social workers, physical therapists), but with CPT codes 98966–98968. The provision, however, has been misapprehended, Fletcher said. "Nowhere does it say medical assistant or nurse."

Another gap in knowledge has been around documentation requirements, Salwin said. It appears many providers are still trying to document telehealth services with the exam, she said. But during the PHE, they only have to use time or medical decision-making to assign an E/M code, because CMS has said it recognizes an exam is limited using audiovisual technology. "For now, you use all the time associated with the E/M service on the day of the encounter, from start to finish," Salwin noted. That won't be the case when the 2021 Medicare Physician Fee Schedule regulation takes effect, because it changes the definition of time.[5] She also reiterated that time or medical decision-making (MDM) applies only to 99201–99205 and 99211–99215, and, until January rolls around, the CPT code book only allows providers to use time to assign codes when more than 50% of the encounter is for counseling or coordination of care. "In 2021, the American Medical Association's MDM and time requirements associated with 99201–99205 and 99211–99215 are increased and are more detailed," Salwin said. "Time is 'longer' for each code, and MDM has some differences compared to what we are accustomed to considering when choosing a code."

'It's a Start-to-End Workflow'

The provider optimization team at Novant Health in North and South Carolina and Virginia developed processes and templates to distinguish up front whether a physician has an audiovisual, telephone-only or in-person visit, said Jill Anderson, assistant director of compliance for the physician network. Billing is tied to that, with modifiers and place of service codes indicating where the patient was seen. "It's a start-to-end workflow," Anderson said.

During the PHE, Medicare is not requiring place of service 02 to be submitted to indicate a telehealth visit, Anderson said. Instead, providers are allowed to report modifier 95 for telehealth visits, along with the place of service (e.g., 11 for a freestanding clinic). When the patient is registered, a note is dropped in that indicates how the services will be delivered, and that supports billing on the back end. "Documentation in the medical record looks different and claims look different for all these scenarios," she noted. For video visits, documentation indicates that both audio and visual technology were used and modifier 95 is appended to the services on the claim to indicate telehealth, Anderson explained. For telephone encounters, documentation indicates an audio-only interaction, and the claim shows a telephone-encounter CPT code. "Traditional face-to-face encounters will not have these types of statements and will bill without a telehealth modifier to denote the office visit," she explained.

Novant isn't worried about overpayments in terms of telehealth vs. face-to-face visits, because Medicare pays the same either way during the PHE, said Kelly Patterson, senior director of compliance for the physician network. Even so, telehealth will be added to its work plan later this year, although "we're spot-checking now," she said. "For a lot of our providers, this is very new, and they are overly cautious their documentation is there. The situation is helping them prepare for guidance that goes into place in 2021" for outpatient/office visits, Patterson said.

CMS Proposes Home Health Telehealth After PHE

Telehealth services in home health will continue after the PHE is over, according to the proposed 2021 home health payment regulation. But there are limitations, said attorney Marcia Augsburger, with King & Spalding in Los Angeles. "I hope it doesn't signal CMS will be super conservative" when it expands telehealth in other areas.

In the regulation, CMS proposed to finalize provisions in the first PHE interim final rule[6] that allows home health agencies to use various kinds of telecommunications, on top of remote patient monitoring, "in conjunction with in-person visits." The technology must be related to the skilled services provided by the therapist, nurse or therapy assistant during the home health visit and "must be included on the home health plan of care along with a description of how the use of such technology will help to achieve the goals outlined on the plan of care without substituting for an in-person visit as ordered on the plan of care," according to the rule.

Although CMS "did more in two weeks to increase reimbursement for telehealth than it did in 29 years" because of the pandemic, this proposal for a permanent change may result in a big reimbursement cut to home health agencies, Augsburger said. "Redoing the plan of care to incorporate telehealth visits may give physicians some additional reimbursement—$50–$112 per month depending on various factors—and if those physicians add telehealth visits to the plan of care, the home health agency that must perform those services will not receive additional reimbursement for them because these agencies are paid a fixed sum per patient based on the number of in-person visits," she said. The proposal also is somewhat burdensome, because telehealth visits can't be a substitute for in-person visits, Augsburger said. Avoiding in-person visits is usually where the return on investment is for telehealth providers, but not under the interim final rule. "If the physicians decide that the telehealth visits they add to a plan of care obviate the need for one or more in-person visits, the home health agency's reimbursement will drop via a dreaded low utilization payment adjustment from CMS, because only in-person visits count toward the number necessary to qualify for a level of payment. As one of my clients said, more

telehealth visits should enhance the quality of care, but if a lot of physicians consider telehealth visits to make an in-person visit unnecessary, no home health agency will survive." This problem doesn't exist for telehealth under Medicare Part B.

Augsburger hopes CMS is bolder in the Medicare Physician Fee Schedule regulation, although in the past CMS has said its hands are somewhat tied by the statutory originating site requirement, which only Congress can remove for good.

There will come a time when the PHE ends, and providers have to plan for how that may play out in terms of telehealth. "I have a number of clients that have been very opportunistic in building out, and I have to warn them, 'You are building a business model, and you don't know when the rug could be pulled out from under you,'" Ferrante said. "While many of these exceptions will continue, we know some will sunset."

One of the most popular exceptions came from the Drug Enforcement Administration (DEA), which allows telehealth for prescribing controlled substances (e.g., medication-assisted treatment for opioid use disorders) without an initial in-person visit during the PHE. If companies expand substance abuse and mental health clinics and are relying partly on telehealth, but the patient and physician have never been in the same room for an in-person visit, the physician won't be able to prescribe controlled substances when the PHE ends, Ferrante said. "It's working now and you can grow fast, but if the law reverts back, the model may not be able to continue as-is in a compliant way."

Amid all the enthusiasm for telehealth services, Fletcher is a voice of skepticism. "People are saying it's the answer to our prayers…but it's not perfect." Although telehealth is necessary during a pandemic and generally appropriate for people in remote areas, Fletcher said the technology has limitations, and some physicians are relying on patients' self-reporting (e.g., blood pressure), which may be unreliable. She also worries telehealth isn't up to the task of treating chronic conditions and opens the door to absurdity and abuse. "I had an acupuncturist tell me he wanted to do telehealth."

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1 Office of Inspector General, "Use of Medicare Telehealth Services During the COVID-19 Pandemic," Work Plan, accessed July 9, 2020, https://bit.ly/31FT96m.
2 Medicare and Medicaid Programs; CY 2021 Home Health Prospective Payment System Rate Update; Home Health Quality Reporting Requirements; and Home Infusion Therapy Services Requirements, 85 Fed. Reg. 39,408 (June 30, 2020) , https://bit.ly/2Z9vSrT.
3 Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, H.R. 748, March 27, 2020, https://bit.ly/2xMtITW.
4 CMS, *COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing*, updated June 19, 2020, https://go.cms.gov/2W7cjzj.
5 Nina Youngstrom, "New E/M Documentation Guidelines, Table Take Effect Soon; 'There Is a Different Mindset,'" *Report on Medicare Compliance* 29, no. 19 (May 18, 2020), https://bit.ly/2BIbF3C.
6 Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 Fed. Reg. 19,230 (April 6, 2020) , https://bit.ly/3c4dqo1.