

Navigating Telehealth: *A Comprehensive Overview*

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- Telehealth Services
- Billing & Coding
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- Documentation & Coding Tips
- Licensure Requirements
- 2024 Physician Fee Schedule (PFS) Proposed Rule
- High-Risk Areas in Telehealth
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- Questions

Meet the presenter

- **Kapil**, a seasoned consultant at **Source 1 Healthcare Solutions**, brings a wealth of experience in the field of compliance. His expertise has been instrumental in shaping the operations of prominent Telehealth Providers, including **K Health**, **Mayo Clinic**, and **Cedars-Sinai**.
- Kapil's academic pursuits in **neuroscience** and **healthcare administration** have equipped him with an understanding of the healthcare landscape. Further strengthening his profile is a certification in healthcare privacy. His unique blend of practical experience and academic knowledge positions him as an asset in the healthcare industry.

What is Telehealth?

- **4 Mechanisms:**
- Synchronous care
- Asynchronous Telehealth
- Mobile Health (mHealth)
- Remote Patient Monitoring (RPM)

Telehealth Services

- Virtual Telehealth Visits with Healthcare Providers
- Online Digital Visits (check-ins)
 - To evaluate whether an office visit is warranted
- Remote Monitoring of Patients
 - Collecting and interpreting physiological data digitally stored or transmitted to the provider
- Telephone Evaluation and Management Service
 - Via audio-only telephone communications
- Behavioral Health Services via Telehealth
- [Full List of Telehealth Services for Calendar Year 2023](#)

Distant vs Originating Sites

- **Originating Site:**
 - A telemedicine site where the beneficiary receives the telemedicine service
- **Distant Site:**
 - A telemedicine site where the health care provider providing the telemedicine service is physically located

Billing & Coding: Telehealth Visits

Telehealth Visits

Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M)

Code	Description
CPT Code 99202-99205	Office or other outpatient visit for the evaluation and management of a new patient
CPT Code 99211-99215	Office or other outpatient visit for the evaluation and management of an established patient

*A list of all available codes for telehealth services can be found here:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

Please note—Check with your payer to determine the appropriate Place of Service (POS) code for your telehealth visits. The AMA is aware that some commercial payers are requiring the use of POS 02—Telehealth (The location where health services and health related services are provided or received, through a telecommunication system.) This is important to ensure your telehealth E/M visits are accurately associated with the care of patients for suspected or diagnosed COVID-19.

Billing & Coding: Online Digital Visits

Online Digital Visits

Digital visits and/or brief check-in services furnished using communication technology that are employed to evaluate whether or not an office visit is warranted (via patient portal, smartphone).

Code	Description
CPT Code 99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
CPT Code 99422	11-20 minutes
CPT Code 99423	21 or more minutes
CPT Code 98970*	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
CPT Code 98971*	11-20 minutes
CPT Code 98972*	21 or more minutes
HCPCS Code G2061	Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes
HCPCS Code G2062	11-20 minutes
HCPCS Code G2063	21 or more minutes
HCPCS Code 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
HCPCS Code 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

* CPT codes 98970-98971 were modified in 2020 to match the CMS language captured in HCPCS code G2061-G2063.

Billing & Coding: Remote Patient Monitoring

Remote Patient Monitoring

Collecting and interpreting physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or qualified health care professional.

Code	Description
CPT Code 99453	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 99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days. (Initial collection, transmission, and report/summary services to the clinician managing the patient)
CPT Code 99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
CPT Code 99458	Each additional 20 minutes (List separately in addition to code for primary procedure)
CPT Code 99091	Collection and interpretation of physiologic data (e.g., ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days)

**Important Use Case—leverage CPT codes 99453 (if patient education is performed) and 99457 to manage pulse oximetry data from the patient's home to keep them out of the emergency room and the inpatient hospital, unless it becomes necessary.*

Billing & Coding:

Telephone Evaluation and Management Service

Telephone Evaluation and Management Service

Evaluation and management visits via audio-only telephone communications

Code	Description
CPT Code 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
CPT Code 99442	11-20 minutes of medical discussion
CPT Code 99443	21-30 minutes of medical discussion

Billing & Coding: Common Pitfalls (HHS)

- **Incorrect Billing Codes**
 - More than 100 telehealth services are currently covered under Medicare, some only temporarily
- **Documentation**
 - Post-visit documentation must be as thorough as possible to ensure prompt reimbursement
- **Code Categories**
 - Telephone codes for audio-only appointments; office codes for audio/video visits
- **Time of Visit**
 - Only bill for time a provider spends with a patient
- **Store-and-forward**
 - Many states require services to be delivered in “real-time”; store-and-forward visits unlikely to be covered → find state-specific information [here](#)
- **Originating and Distant Sites**
 - Learn more about eligible sites [here](#)

Documentation requirements

- *To ensure appropriate payment, the following documentation elements should be captured:*
- Date of the visit
- Consent for the telehealth visit from patient or patient representative (verbal or written)
- Category for office visit → real-time audio with video or audio/telephone only
- Date the patient was last seen or was billed for correspondence to avoid date overlap with other billable services
- Patient location for the visit
- Provider location for the visit
- Start time and end time for telehealth encounter
 - Length of time billing provider spent on the date of the visit and how time was spent if billing by time or a time-based code
- *The requirements listed above are in addition to all standard E/M documentation requirements*

Documentation & Coding Tips

- *Timely and correct payment depends on complete and accurate documentation and codes*
- Work closely with your staff to understand documentation and coding requirements
- Document and code for the place of service (POS)
 - For Medicaid, reach out to your state agency
 - For private, POS code requirements may vary
- Try to verify that your documentation supports the codes used
- **For Medicare:**
 - **Use the POS code you would've used if the service was provided in person**
 - **Use the CPT modifier 95 for telehealth services provided in real-time**
 - **Before submitting a claim, verify that the service provided is included on the list of available codes for telehealth (based on payer guidelines)**
- Example of a common mistake:
 - For Highmark, place of service is 02 if the patient is *not* in their home while place of service is 10 if patient *is* in their home

Licensure Requirements

- No additional requirements if you are licensed in the state where the patient is located
- If you are not, options vary by state, but generally:
 - Interstate Medical Licensure Compact
 - Licensure by endorsement
 - Special purpose telehealth registry or license
- **There are exceptions to these requirements based on State guidelines**

2024 Physician Fee Schedule (PFS) (Now) final Rule

- **Classification of covered services:**
- Currently classified using 3 categories:
 1. consultations, office visits, office psychiatry visits (E/M)
 2. other services not currently on the Medicare Telehealth Services List that are under review by CMS
 3. Services added during COVID-19 PHE that have not yet been determined to be permanently on the list of covered services
- Potential classification going forward
 - Either Permanent or Provisional Services
 - CMS has a 5-step process they want to implement to filter between the two categories

2024 Physician Fee Schedule (PFS) (Now) final Rule

- Consolidated Appropriations Act (CAA) of 2023 & CMS have extended key policies
 - Added a beneficiary's home as an eligible originating site at which the beneficiary can access telehealth services
 - Select non-behavioral telehealth services can be provided via audio only (list [here](#))
 - Geographic and originating site restriction on Medicare Telehealth Services waived (through December 2024)
- Extension of Direct Supervision via two-way audio/video technology (
 - CMS allowed the supervising professional to be "immediately available" through a virtual presence
 - This allowance has been extended through 2024

2024 Physician Fee Schedule (PFS) (Now) final Rule

- Behavioral Health
 - In-person requirement on Medicare tele mental health services delayed until January 2025
 - CMS proposes that telehealth services furnished to beneficiaries in their homes be permanently paid at the higher, non-facility PFS rate.
 - CMS proposes to modify Place of Service (POS) modifiers that clinicians use to bill for telehealth services
 - POS 10 → services furnished to a beneficiary in their home, at the higher non-facility rate
 - POS 02 → services when a patient is not in their home at the lower, facility rate
 - New HCPCS codes for psychotherapy for crisis services
 - Payments for these services would be equal to 150% of the fee schedule amount
 - 90839 → first 60 minutes
 - 90840 → each additional 30 minutes (in conjunction with 90839)
- Audio-only services will be paid until December 31, 2024

2024 Physician Fee Schedule (PFS) (Now) final Rule

- Diabetes Self-Management Training (DSMT) Services
 - Currently requires 1 hour of the 10-hour DSMT benefit's initial training and one hour of the 2-hour follow-up annual training to be furnished in-person
 - Proposing to eliminate the regulatory prohibition on providing the full service via telehealth
 - Should promote access to DSMT services, which are underutilized services that have shows to improve patient care

Other Proposed Policies

- CMS proposes to increase the payment amount for the telehealth originating site fee
 - HCPCS code Q3014: \$29.92
- CMS proposes to remove the telehealth frequency limitations for CPT codes 99231-33, 99307-10 that pay for telehealth services in skilled nursing facilities and for critical care consultation services until the end of 2023
- CMS proposes to codify billing rules for Diabetes Self-Management Training (DSMT) services furnished through telehealth
 - Allows distant site practitioners to bill DMST services furnished via telehealth
- DEA extended its PHE policies on covered healthcare on prescribing controlled substances based on telehealth visits (through November 11, 2023)
- Remote Patient Monitoring
 - Now must have an established relationship
 - RPM must be reported for 16 days (again)
 - Waiver for enforcing LCDs on therapeutic continuous glucose monitors has ended

High-Risk Areas

- **OIG's 7 Program Integrity Measures:**

1. Billing telehealth services at the highest, most expensive level for a high proportion of services, including E/M services → could indicate upcoding
 - OIG considers providers to be at high risk if they billed 100% of their telehealth services at the highest level
2. Billing a high average number of hours of telehealth services per visit
 - OIG considers a provider to be at high risk if they billed for an average of 2 hours of telehealth services per visit
→ *you should only be billing for time the provider spends with the patient*
 - Medicare median time was 21 minutes per telehealth visit
3. Billing telehealth services for a high number of days in a year
 - OIG considers providers to be high risk if they billed telehealth services for more than 300 days in the year
 - Telehealth services were provided to Medicare patients a median of 26 days per year across all providers
4. Billing telehealth services for a high number of patients → may indicate a provider is billing for services not actually provided
 - OIG considers a provider to be at high risk if they billed for more than 2,000 beneficiaries

High Risk Areas

- **OIG's 7 Program Integrity Measures (continued):**

5. Billing multiple plans or programs for the same telehealth service for a high proportion of services
 - If they billed both Medicare fee-for-service and a Medicare Advantage plan for the same service for more than 20% of their services
 6. Billing for telehealth service and then ordering medical equipment for a high percentage of patients
 - If they ordered supplies within 3 months of telehealth services for at least 50% of beneficiaries
 - Also, if they billed primarily for audio-only services before ordering medical equipment → this pattern could indicate that providers are cold-calling beneficiaries to increase orders
 7. Billing for both a telehealth service and a facility fee for most visits.
 - More than 75% of visits
 - Certain providers will fall into this high-risk category by the nature of their practice or patient base
 - These providers should place additional focus on compliance efforts in case the provider's claims come under great scrutiny
- *Providers whose billing practices fall below OIG's "high-risk" thresholds should not consider themselves immune from scrutiny, especially where a provider's claims demonstrate more than one of the factors listed above.*

Top 10 Take Aways of Telehealth

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- 1. **Telehealth compliance:** Telehealth services are subject to myriad state and federal healthcare regulations
- 2. **Data privacy and security:** Providers should ensure that data stays private and secure when providing telehealth services
- 3. **State licensure laws:** Providers servicing patients in other states or countries need to be aware of licensure laws in the jurisdictions where the patients are located
- 4. **Corporate structure** : Several states prohibit the corporate practice of medicine, which impacts how a telehealth platform is structured as the platform itself is typically a lay entity and not permitted to directly employ or contract with practitioners to provide professional telehealth services in these states
- 5. **Reimbursement for telehealth services:** Reimbursements for telehealth continue to evolve
- 6. **Medicare payment policies:** The Centers for Medicare & Medicaid Services (CMS) has expanded coverage for telehealth service
- 7. **Telehealth trends:** Telehealth will only continue to grow if physicians and other healthcare providers are being paid properly for their services
- 8. **Telehealth policy changes after COVID-19**
- 9. **Billing tips for providers:** Provider, Payer, Federal, and State Laws will most likely change in 2024, telehealth is still quite new and the government is still catching up.
- 10. **Documentation and Coding Requirements:** Documentation requirements can be quite extensive and coding requirements can be confusing so pay close attention to the variances between payers.