Outpatient Services Supported by Telehealth 2021

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Disclaimer: *This presentation is offered as guidance to NEPHO providers and office administration. If you are a BILH employed practice please follow up with your practice Leadership on guidance reviewed during this presentation.*

Agenda

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- 2021 Telehealth Updates
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  - Lifting Restrictions
  - Payer Parity
  - Frequency Limitation Updates for Telehealth in Nursing Facilities
  - Technology Based Services
  - State Licensing Updates – Providing Services Across State Lines
- Telehealth Supported Services
- Documentation Review
  - Documentation Requirements
  - Documentation Examples

Redefining the Telehealth Rules

- The following two services must be initiated by the patient and there cannot be an Evaluation and Management (E/M) service in the preceding seven days or in the subsequent 24 hours:
  - Internet is when communication is not synchronous and over the internet, such as email.
  - Telephone consultation (Referral to Specialist) can be provided to another clinician but requires that there have been no E/M service by the consultant within the past 14 days or within the next 14 days, and there must be documentation of a verbal and written report back to the consulting clinician.
  - Video/Audio
  - Audio Only
- Documentation requirements should follow 2021 E/M updates.
- Including time spent during Video/Audio & Audio Only would help support Telehealth billing.

Services Now Supported By Telehealth

- Blood Pressure Management
- Behavioral and Mental Health
- Chronic Condition Management
- Everyday Care
- Acute & Urgent Primary Care
- Health Coaching
- Wellness and Preventive Care

Lifting Restrictions In Massachusetts

- Waive geographic restrictions, allowing patients located in any geographic area—both non-rural and non-health professional shortage areas—to receive telehealth services
- Waive originating site restrictions, meaning patients can receive telehealth services in the comfort of their own homes
- Allow the use of telephones that have audio and video capabilities to administer telehealth services
- Allow reimbursement for any telehealth covered code, even if unrelated to COVID-19 screening, diagnosis, or treatment
- Halt the enforcement of the established relationship requirement, meaning that HHS will not conduct audits to ensure a prior physician/patient relationship existed before the crisis
- The Office of the Inspector General also announced that physicians and other healthcare practitioners now have flexibility in reducing or waiving cost-sharing obligations for telehealth visits that are paid by federal healthcare programs. Prior to this announcement, Medicare only covered costs for telehealth on a limited basis.
- Additionally, the Office for Civil Rights announced that for the duration of the crisis it will exercise enforcement discretion and waive penalties for HIPAA violations against providers that serve patients in “good faith” through commonly-used communication apps such as Skype or FaceTime.

Massachusetts Legislative Bill Signed 1/1/2021

- Strengthening Telehealth Coverage: Mandates permanent payment parity for Behavioral Health services and established parity for Primary Care and Chronic Care Management for the next two years.
- Currently Audio only and E/M (face-to-face) are being reimbursed equally – this bill will help keep this balance in place as we move past the pandemic.
- It requires payers to cover all such services delivered via telehealth that are also offered in-person, and to reimburse providers at the same rate.
- Permanent Expansion for scope of practice for NPs, Nurse Anesthetists, Psychiatric Nurse Mental Health Specialists & Optometrists.
- Protects consumers from surprise billing – the bill requires providers to notify patients if procedure is in or out of network – There is work being done to have a default rate for out-of-network billing by 9/1/2021.

Service Frequency Updates for Nursing Home Care

- CMS is reducing the frequency limitation for coverage of subsequent nursing facility care services furnished via telehealth from once every 30 days to once every 14 days.
- The original 30-day restriction was due to concerns on the acuity and complexity of nursing facility residents, and to ensure nursing facility residents have frequent encounters with their admitting practitioner.
- CMS was persuaded that the use of telehealth is crucial to maintaining continuity of care in nursing facilities, and to honor the independent medical judgment of treating clinicians to decide whether telehealth vs in-person care should be used, depending on the needs of each specific resident.
- Frequency limitations have already been temporarily waived for the duration of the PHE, but this new rule change is permanent, effective January 1, 2021.
- CMS declined to make any changes to the telehealth frequency limitations for hospital inpatient visits and critical care consultations.

Technology Based Services

Audio Only Coding & Billing

Telephone or audio-only evaluation and management services for new and established patients cannot originate 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.

- 99441: 5-10 minutes of medical discussion
- 99442: 11-20 minutes
- 99443: 21-30 minutes

Digital E/M Services

Online digital E/M services for established patient for a period of up to 7 days, cumulative time during the 7 days. These codes can be billed once a week and cannot be billed within a 7-day period of a separately reported E/M service, unless the patient is initiating an online inquiry for a new problem not addressed in the separately reported E/M visit. These services must be initiated by the patient (e.g., patient portal, e-mail). **Medicare will cover these services for new patients during the public health emergency.**

Physicians report:	Qualified Non-Physician Professionals report:
99421: 5-10 minutes	98970: 5-10 minutes
99422: 11-20 minutes	98971: 11-20 minutes
99423: 21 or more minutes	98972: 21 or more minutes

Audio Only Visit Updates

The new bill mandates that the Group Insurance Commission and all Carriers shall not impose any specific requirements on the technologies used to deliver telehealth services (including any limitations on audio-only or live video technologies). Audio only telehealth codes currently approved that they only be used during the PHE, this code could extend beyond the PHE. The communication technology must be synchronous and is subject to the same billing requirements as the other virtual services. CMS will consider whether this interim policy should be adopted permanently.

Codes: 99441, 99442, 99443 - non face-to-face telephone only (Audio Only)

- 99441: 5-10 minutes of discussion
- 99442: 11-20 minutes of discussion
- 99443: 21-30 minutes of discussion

State Licensing Guidance

- We urge each provider to be licensed in the state where the patient is located, unless there are provisions in place otherwise due to the pandemic.
- Keep a continuous eye on the changes for each state that you are seeing patients in and do not hold a license to practice, as changes are fluent.
- Federation of State Medical Boards that provides guidance by state, as each state has put in place their own rules and regulations in response to the pandemic - https://www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf
  - The FSMB website breaks down state specifics surrounding out-of-state physicians; pre existing provider-patient relationships; audio-only requirements; etc.

Services Supported by Telehealth

CMS also finalized its proposal to allow all Category 3 telehealth services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic to remain on the list through the calendar year in which the PHE ends. These Category 3 services include the following:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facilities discharge day management (CPT 99315-99316)
- Psychological and Neuropsychological Testing (CPT 96130- 96133; CPT 96136- 96139)

Services Supported by Telehealth (continued)

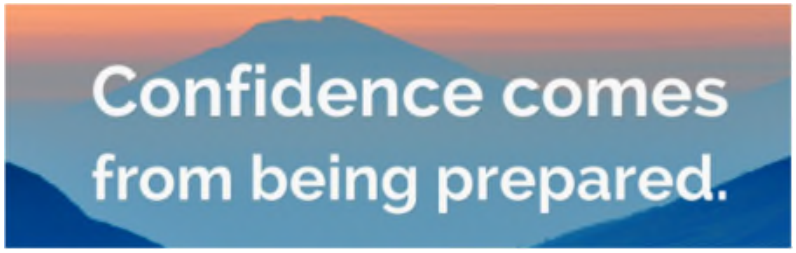
- Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- Hospital discharge day management (CPT 99238- 99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT 99478- 99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)

Documentation Requirements for Telehealth

- Providers delivering services via telehealth must meet all health records standards required by the applicable licensing body as well as any applicable regulatory and billing provisions.
- Providers must include a notation in the medical record that indicates that the service was provided via telehealth and confirm patient identity (e.g., name, date of birth or other identifying information as needed).
- If a service code is time-based, evidence of time must be documented.
- Best practices suggest including:
  - A statement that the service was provided using telemedicine or telephone consult.
  - The location of the patient.
  - The location of the provider
  - The names of all persons participating in the Telehealth service and their role in the encounter.

Our Recommendations

- Before the pandemic, seeing patients across state lines via telehealth without being licensed in the state the patient was physically sitting in was considered practicing without a license. The dust is still settling - although telehealth is the new normal, state medical boards will continue drive their own rules and regulations.
- We recommend you begin to analyze patient data to determine where your patients are living to best determine the states that each provider would benefit in obtaining a state license within.
- Additional licensing guidance can be found at: https://www.nepho.org/nepho-out-of-state-licensing-guidance/



E/M Time Leveling Redefined

- New Patient Codes
  - 99202: 15-29 minutes
  - 99203: 30-44 minutes
  - 99204: 45-59 minutes
  - 99205: 60-74 minutes
- Established Patient Codes
  - 99211: Outlier
  - 99212: 10-19 minutes
  - 99213: 20-29 minutes
  - 99214: 30-39 minutes
  - 99215: 40-54 minutes

New Ways of Thinking

- Understand your patient
  - Age of your patient
  - Reason for Visit/Chief Complaint
- Understand the problem
  - Acuity of problem(s)
  - Chronic conditions/comorbidities
  - Differential diagnosis
- Understand the risks
  - Risks if treated or not treated
  - Risks complicating other problems
  - Social conditions impacting risks

Risk Defined

- **Risk of Complication and/or Morbidity or Mortality of Patient Management**
  - The probability and/or consequences of an event
  - The assessment of the level of risk is affected by the nature of the event under consideration
  - For purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter. Risk includes decisions to initiate, forgo, or decline treatment, management or hospitalization
  - Minimal Risk: Rest & Fluids
  - Low Risk, Moderate Risk, High Risk: Complexity
- **Social Determinants of Health (SDOH)**
  - Food insecurity
  - Housing insecurity
  - Safety
  - Welfare risks
  - Unemployment
  - Inadequate education

MDM Updates

- Revision of MDM definitions
- Number and Complexity of Problems Addressed
- Amount and/or Complexity of Data to be Reviewed and Analyzed
- Risk of Complications and/or Morbidity or Mortality of Patient Management
- There will be a new table for calculating medical decision-making
  - “Number of diagnosis or management options” will become “Number and complexity of problems addressed”
  - “Amount and/or complexity of data to be reviewed” will become “Amount and/or complexity of data to be reviewed and analyzed”
  - “Risk of complications and/or morbidity or mortality” will become “Risk of complications and/or morbidity or mortality of patient management”

Telehealth Documentation Examples

- Document plan of care for chronic conditions, condition status
  - **Example:** A Fib I48.91 – heart rate within normal limits, converting back to normal sinus rhythm, apixaban is helping to regulate heart rate
- Chronic conditions need to be captured/recaptured annually
  - **Example:** Depression (F33.8) or depression in remission (F33.4), Opioid dependence (F11.20) or opioid dependence in remission (F11.21) (Depression: when depression has stabilized coding depression in remission would be appropriate)
- Chronic conditions should be discussed and documented during a new patient visit
  - **Example:** New patient visit with the following chronic conditions: Hypertension I10, CKD stage 3 unspecified N18.30, Recurrent depressive disorder F33.8, Opioid dependence in remission F11.21
- Document confirmed chronic conditions to their highest specificity
  - **Example:** Diabetes with CKD stage 3: E11.22, N18.31 stage 3a (1st code diabetes with chronic kidney disease then code chronic kidney disease)

Telehealth Exam Components Capture

- Exam components to help support a Telehealth exam:
  - HEENT: Use a flashlight or phone based light to look at the throat and nose
  - Skin: Have the patient press on a rash to observe any scaling or redness
  - Cardiovascular: Find pulses at the radial, carotid, femoral and jugular venous
  - Abdominal exam: Have the patient feel for masses and/or describe location of symptoms such as pain
  - Musculoskeletal: Self palpitation can be used to show locations of pain or point of tenderness. Range of motion can be assessed and directed by the provider
  - Neurologic: Observe patient gait, have them squat and get up and down from a chair and/or walk across the room

  Have the patient be more involved and interactive in the visit, have patient family members or care giver offer additional information to better support the reason for the visit. Include their information in the note to help support the visit medical necessity.

NEPHO Coding Support

- Shawn Bromley @ shawn.m.bromley@lahey.org or 978-236-1704
- Helpful Resources:
  - https://emuniversity.com/
  - https://www.mass.gov/info-details/covid-19-vaccine-frequently-asked-questions
  - https://www.mass.gov/info-details/massachusetts-covid-19-vaccine-information
  - https://mhealthintelligence.com/news/baker-signs-massachusetts-telehealth-bill-with-parity-provisions-into-law