On-Demand Webinar: "COVID-19 Compliance Today and Tomorrow"

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Disclaimer: To the best of our knowledge, this information was correct at the time of publication. Given the fluid situation, and with rapidly changing new guidance issued daily, be aware that some or all of this information may no longer apply. Please visit our COVID-19 hub frequently for the latest updates, as we are working diligently to put forth the most relevant helpful guidance as it becomes available.

Additional Questions & Answers:

Q1: You do not have to put the modifier -95 on the G0071 code, do you? For RHCs should the only code for a telehealth visit be G0071?

A1: Code G0071 is used to report 5 minutes or more of a virtual (non-face-to-face) communication between an RHC or FQHC practitioner and the RHC or FQHC patient ***or*** 5 minutes or more of remote evaluation of *recorded* video and/or images by an RHC or FQHC practitioner, occurring in lieu of an office visit. Modifier -95 is used to report *synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system*.

On April 17, CMS released the following guidance for RHC and FQHC virtual communication and telehealth service reporting and billing:

Virtual Communication Services

To receive payment for the new online digital evaluation and management (CPT codes 99421, 99433, and 99423) or virtual communication services (HCPCS codes G2012 and G2010), RHCs and FQHCs must submit an RHC or FQHC claim with HCPCS code G0071 (Virtual Communication Services) either alone or with other payable services. These services are not telehealth services. Therefore, no telehealth modifier is required.

Telehealth Services

For telehealth distant site services furnished between **January 27, 2020, and June 30, 2020, RHCs and FQHCs must put Modifier "95"** (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. Providers may submit any approved code on the telehealth list available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip.

RHCs will be paid initially at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate ($92). **RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.**

For telehealth distant site services furnished between July 1, 2020, and the end of the COVID19 PHE, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be

paid at the $92 rate. Only distant site telehealth services furnished during the COVID-19 PHE are authorized for payment to RHCs and FQHCs. If the COVID-PHE is in effect after December 31, 2020, this rate will be updated based on the 2021 PFS average payment rate for these services, weighted by volume for those services reported under the PFS.

During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. **For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries**. For services in which the coinsurance is waived, **RHCs and FQHCs must put the "CS" modifier on the service line**. RHC and FQHC claims with the "CS" modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived.

Additional information regarding cost reporting requirements, as well as a helpful resource for the information outlined above is available at https://www.cms.gov/files/document/se20016.pdf

Q2: Given the broad range of blanket waivers, is it correct to assume that the condition code DR should be reported on every claim during the pandemic? Are there limitations that would make doing so incorrect?

A2: We understand that the theory is that all claims during the pandemic would have condition code DR to support any variance from the norm (i.e. shorter length of stay, etc.).

However, per CMS, the condition code DR should be used for all billing situations by institutional providers when the items/services billed on the claim are related to the COVID-19 waiver.

Effective August 31, 2009, the use of condition code DR was mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver" (as defined in the CMS Internet Only Manual, Publication 100-04, Chapter 38, § 10).

Additionally, modifier CR is mandatory for reporting for institutional and non-institutional providers to identify Part B line item services/items related to a COVID-19 waiver.

We recommend only billing claims that are tied to a COVID-19 waiver with the DR modifier.

References:

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf

Q3: Are there any changes in CMS's policy on split/shared visits? For example, for incident-to encounters, the MD may be remote (audio and/or video)? Can the physician report the services under the physician's NPI? Thank you!

A3: Billing Split/Shared visits is less of a matter of supervision, but rather a rendering of services by two providers and a determination if the physician provided a substantive E/M on the same date. In the event that a physician provided a substantive portion of an E/M service on the same date as an NPP, you would still bill only one E/M visit under the physician. We would recommend using modifier 95 to indicate that a portion of the visit was via telehealth. Document the scenario well in the record.

We recommend applying the incident-to direct supervision expansion via audio/visual technology to ancillary services only. For example, an RN would go to a patient's home and provide an injection. The injection must be rendered under direct supervision. So, the physician would provide that supervision via real-time audio/visual technology, to meet the requirement. PYA does not recommend using this definition for professional services rendered by an Advanced Practice Provider, such as an E/M service. Those services would be billed under the APP's provider number directly to Medicare.

Q4: How do hospitals bill for telehealth?

A4: Medicare has expanded the originating sites to those eligible sites of service that are outside of rural areas. If a Medicare beneficiary is in a healthcare facility that is on the current list of permissible sites (except for home) and receives a service via telehealth, the health care facility is eligible to bill the originating site facility fee.

Source: https://www.cms.gov/files/document/covid-final-ifc.pdf