Telehealth Billing in the Hospital Setting

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Richelle Marting is an attorney, registered health information administrator, and certified coder who focuses on healthcare coding, billing, and reimbursement issues. She has practical, in-the-trenches experience with coding and billing issues. She has served as an outpatient multi-specialty surgery coder, hospital-based outpatient coder and a compliance coordinator for a large multi-specialty medical group. As an attorney she advises clients proactively on complex reimbursement questions and has guided multiple clients through extensive Medicare and OIG audits and investigations.
Breaking News
New Telehealth Place of Service Code

Professional Telehealth in the Hospital Setting

Overview

Hospital Facility
Telehealth Billing
National Code Set
Expanding POS 02
Telehealth in to 02
and 10 to
distinguish
telehealth at home

Breaking News: New Telehealth Place of Service Code
<table>
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<th>02 Telehealth Provided Other than in Patient’s Home (January 1, 2017)</th>
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<tr>
<td>The location where health services and health related services are provided or received, through telecommunication technology. <strong>Patient is not located in their home when receiving health services or health related services through telecommunication technology.</strong> (See “Special Considerations” below.)</td>
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<th>10 Telehealth Provided in Patient’s Home (January 1, 2022)</th>
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<td>The location where health services and health related services are provided or received, through telecommunication technology. <strong>Patient is located in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.</strong> (See “Special Considerations” below.)</td>
<td><strong>Not applicable for adjudication of Medicare claims; systems must recognize for HIPAA</strong></td>
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Hospital as Originating Site

- Originating site fee Q3014 is reported to Part B MAC
- Paid outside other payment methodologies (i.e. DRG, cost-based, APCs)
- 2021 Rate is $27.02
- Medical staff considerations of the distant site provider seeing your hospital inpatient/outpatient
Generally, any provider rendering telehealth to a hospital patient has to be on the medical staff with privileges at the originating site hospital.

Medical Staff Considerations for Hospitals

42 CFR §482.12(a) options for medical staff of distant site provider:

- Written agreement with a distant site hospital
- Distant site hospital agrees to meet medical staff standards of Medicare Conditions of Participation
- Originating site hospital could grant privileges based on staff recommendations of distant-site hospital
- Specify distant site hospital is a contractor
- Directly consult with distant site provider periodically

*Waived during the PHE*
A hospital contracting for telehealth services must also comply with Medicare’s “Contracted Services” requirements.

Medical Staff Considerations for Hospitals

42 CFR §482.12(e): Contracted Services

- Ensure services are performed in a safe and effective manner
- Maintain a list of all contracted services, including the scope and nature
Licensing Requirements

When telemedicine is used and the practitioner and patient are located in different states, the practitioner providing the patient care service must be licensed and/or meet the other applicable standards that are required by State or local laws in both the state where the practitioner is located and the state where the patient is located.

Typically, providers must be licensed in the state where the patient is located in order for telehealth to be paid by Medicare.

*Waived during the PHE* a payment rule, not a licensing rule
 TELEHEALTH CONTRACT CONSIDERATIONS

• Licensing
• Medical staff appointment
• “Telehealth Privileges”
• Credentials, privileges
• Due diligence when relying on others’ screening processes
• Insurance coverage
• Documentation – whose system?
• Encounter reports
• Billing, reassignment
• Medicare, private health plan participation statuses
• Coordination, review of services
Temporary Expansion Sites

- Hospitals can ‘expand’, making patients’ homes provider-based outpatient locations
- May occur without a related professional service
- Requires a relocation enrollment process with Medicare
- Patient becomes a registered outpatient of the hospital
- All services still require provider order and supervision
- Billed ‘as if they were furnished in the hospital’ with modifier –PO; HOPPS rate
- If relocation process not followed, bill with –PN; paid at PFS rate
Temporary Expansion Sites: Example

- Hospital clinical staff remotely furnish psychotherapy (90832) to patient at home
- Patient is registered as an outpatient of the hospital
- Patient’s home is made a provider-based outpatient department (an enrollment/relocation process)
- If hospital has followed provider-based outpatient department relocation process, report 90832-PO to be paid regular HOPPS rates
- Hospital can also report originating site fee for telehealth service
Professional Telehealth Services in the Hospital Setting
Restrictions on distant site practitioner qualifications are dictated by regulation, not statute.

Eligible Distant Site Professionals

- Social Security Act (1834): “Physician or practitioner”
- CMS regulation (42 CFR 410.78): “practitioner”
  - physician
  - physician assistant
  - nurse practitioner
  - clinical nurse specialist
  - nurse-midwife
  - clinical psychologist
  - clinical social worker
  - registered dietitian or nutrition professional
  - certified registered nurse anesthetist
Telehealth for Stroke Care

- Services for the diagnosis, evaluation, treatment of acute stroke
- Permanent, pre-COVID rule from 2019: no geographic, originating site restrictions
- Hospitals can be originating sites (Q3014)
- Modifier –G0 (zero) on both originating site and distant site professionals’ claims
  - Generally reported with POS 02 (PHE POS guidelines differ)
  - Eligible with CAH Method II claims (rev 096x, 097x, 098x)
  - Originating site fee Q3014
- Consider diagnosis code assignment for acute stroke

Even outside of COVID-19 PHE flexibilities, telehealth for acute stroke care can be provided regardless of originating site or geographic area
Critical care codes are temporarily added as covered telehealth during the PHE

Telehealth and Critical Care

- Currently, end of the calendar year when PHE ends*
- Medicare Proposed Rule for 2022 would extend through 12/31/2023
- Medicare Proposed Rule for 2022 would significantly change critical care coding and billing
**TELE-CRITICAL CARE CODING**

- 99291  Critical care, first hour*
- 99292  Critical care, each additional 30 min*
- G0406  Inpt/tele consult follow up limited, 15
- G0407  Inpt/tele consult follow up intermediate, 25
- G0408  Inpt/tele consult follow up complex, 35
- G0425  Inpt/ed teleconsult 30 min
- G0426  Inpt/ed teleconsult 50 min
- G0427  Inpt/ed teleconsult 70 min
- G0508  Crit care telehealth consult 60*
- G0509  Crit care telehealth consult 50*

*Not eligible for audio-only*
Critical Care

Proposed adopting CPT rules, including definition and bundled services, with certain exceptions

Changes

Allow as concurrent care regardless of group affiliation

All providers in the same group, same day, same patient combine time to determine 99291, 99292 units

99291 once per day, per patient, per group

Provider reporting more than 50% of time bills

No other E/M visit for the same patient, same day as critical care by provider in same specialty and group

Bundled into post-op for 10-, 90-day procedures

Other Provisions

Start/stop times not required

Sufficiently document to allow reviewer to determine role each professional played
During PHE, teaching physician ‘presence’ during key component can be met through “audio-visual telecommunications technology”

Medicare is seeking comment on whether to extend and/or make supervision rules permanent

Whether to allow only for a subset of services

Whether modifier would be needed

**Virtual Presence**

Permitted through end of calendar year when PHE ends

**Immediate Availability**

Provider must be immediately available to engage via interactive technology

Real-time presence throughout the service is not required

**Interactive Technology**

Interactive, audio/video, real-time communications technology

Audio-only excluded

**Supervision**

- During PHE, teaching physician ‘presence’ during key component can be met through “audio-visual telecommunications technology”
- Medicare is seeking comment on whether to extend and/or make supervision rules permanent
- Whether to allow only for a subset of services
- Whether modifier would be needed
Questions?

Available Through Heartland Telehealth Resource Center for Technical Assistance
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