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Overview

- LTC Facility as Originating Site
- Initiating SNF Care
- Split/Shared Visits
- Therapy and Care Management
SNF ADMISSION

- 3-day qualifying hospital stay waived during COVID
SNFs are eligible originating sites by Medicare statute.

**LTC Facilities as Originating Sites**

*Assisted living place of service 13, but some guidance that ALFs may be patient’s home*

*Independent living facility place of service 12*

*But, Medicare Advantage plans have been able to offer expanded coverage to patients at home or in LTC facilities since 2019*
INITIATING SNF CARE VIA TELEHEALTH

- 99304-99306 Initial Nursing Facility Care: Temporary Addition for the PHE for the COVID-19 Pandemic
  - Physician certification on admission or as soon as practicable thereafter
  - Attending physician or provider with knowledge of the case
  - Typically in-person visit (outside COVID rules)
  - In-person requirement waived during the PHE

- 99307 – 99310 Subsequent Nursing Facility Care: Permanently Permitted Via Telehealth
  - Frequency limit waived during PHE
  - Outside PHE, limit once every 14 days (used to be 30)
Split/Shared Visits in LTC

Generally when both a non-physician-practitioner and physician from the same group practice see the patient the same day

When split/shared rules are met, services can be billed under physician’s name and number and receive higher physician reimbursement
SPLIT/SHARED VISITS

- One E/M per provider, per patient, per day (concurrent care rules exception)
- Two providers, same group practice, same patient, same day
- Each perform “substantive” portion of a face-to-face E/M visit
- Previous rules were in Medicare IOMs only; never went through rulemaking
- 2020 Good Guidance Regulations
- Application to withdraw split/shared rules from IOM
- Withdrawn May 2021
- Proposed rule July 2021
- Final rule effective January 1, 2022
SPLIT/SHARED VISITS

- Allowed for both new and established patients (initial and subsequent)
- Previously not allowed in the SNF setting
- 42 CFR 483.30 – some visits must be performed in their entirety by a physician
  - Mandatory physician visit every 30 days for first 90 days; every 60 days thereafter
  - Initial visit must be personally performed by physician
  - Thereafter, may alternate with a PA, APRN, CNS
- Split/shared allowed in SNF setting; extends to telehealth
- During COVID, could be initial visit and alternative visits thereafter
SPLIT/SHARED VISITS

- Facility setting only (SNF/NF but not AL, IL)
- Does not require each provider have a face-to-face
  - In the context of telehealth, does not require each provider join the telehealth session
- Substantive portion determines billing provider
  - > 50% of time
  - Even if levels are selected based on key components
- 2022 transition year
  - 1 of 3 key components or > 50% of time
  - Billing provider perform 1 component in its entirety at the level billed
- Only distinct time counts
- Modifier –FS required if physician bills
3. **Question:** In order to help minimize unnecessary person-to-person contacts during the current PHE, is it permissible for clinical social workers (CSWs) to conduct their visits to Part A SNF residents remotely? If so, are such services subject to consolidated billing (CB, the SNF “bundling” requirement for services furnished during the course of a Medicare-covered stay)?

**Answer:** The option to conduct their SNF visits remotely is always open to CSWs, regardless of whether a PHE is in effect. Moreover, the CB rules that apply to bundled services (such as CSW services that are furnished to a SNF’s Part A resident) do not change merely because the services in question happen to be rendered remotely rather than in person; accordingly, such services when conducted remotely would remain subject to CB.

New: 3/26/20
THERAPY IN THE SNF

5. Question: In order to help minimize unnecessary person-to-person contacts during the current public health emergency (PHE), is it permissible to provide therapy services to Part A SNF residents remotely? If so, are such services subject to consolidated billing (the SNF “bundling” requirement for services furnished during the course of a Part A Medicare-covered stay)?

Answer: Yes, therapy services furnished to a Part A SNF resident may be furnished remotely during the COVID-19 PHE (consistent with state scope of practice laws), based on the clinical judgment of the therapist that the therapy being furnished is appropriate to be provided remotely and continues to meet the SNF level of care requirements. Moreover, the consolidated billing rules that apply to bundled services (such as therapy services that are furnished to a SNF’s Part A resident) do not change merely because the services in question happen to be rendered remotely rather than in person; accordingly, such services when conducted remotely would remain subject to consolidated billing. Therapy services, such as those furnished by Physical Therapists, Occupational Therapists, and Speech Language Pathologists, to SNF residents who are not in a covered Part A SNF stay may be payable under the Part B Physician Fee Schedule, when reasonable and necessary. In these instances, PT, OT, and SLPs should follow the telehealth and CMS billing policies for Part B, including “Part B” consolidated billing, under which therapy services furnished to a SNF resident during a non-covered stay (Part A benefits exhausted, SNF level of care requirement not met, etc.), whether in person or by telehealth, must be billed to Part B by the SNF itself using bill type 22X.

New: 6/19/20
THERAPY IN THE SNF

- Therapy codes temporarily added to telehealth list
- Modalities generally during PHE only
- PT/OT/ST evaluations through 12/31/23

- Added by KMAP for COVID-19 3/12/20
  - Some audio-only allowed
  - In effect until rescinded
  - See CPTs 97140 – not on CMS list

- Added by Missouri 5/21/20
  - Has not been rescinded
  - See CPT 97533 – not on CMS list
TRANSITIONAL CARE MANAGEMENT

- Transitional Care Management 99495, 99496
- Medicare telehealth service; impact on requirements after PHE
- Communication with the patient within 2 business days of discharge
- Moderate, high complexity MDM
- Face-to-face visit within 14 calendar days (mod complexity MDM) or 7 calendar days (high complexity MDM) of discharge
- Face to face component can be telehealth; not separately reportable
CARE MANAGEMENT

- Chronic care management
- Behavioral health integration
- Psychiatric collaborative care
- Remote patient monitoring
- Remote therapeutic monitoring (consider PT, OT, ST implications)
- Behavioral screenings, evaluations, testing, assessments, interventions
- Home visits (e.g. IL)
- Phone visits 99441-99443 (ends when PHE ends)
HOSPICE CERTIFICATION, RECERTIFICATION

- Hospice Certification: 42 CFR 418.22
  - Certifying patient is terminally with prognosis of a life expectancy of 6 months or less
  - Beginning of first 90-day period
  - Subsequent 90 day period
  - Every 60-day period after
  - **Face-to-face** if patient reaches 3rd benefit period
  - Hospice physician or APRN
  - Not a separately billable service on its own; administrative in nature
- **Note:** Attending physician can be physician, APRN, or PA. An attending providing medically necessary service could perform certification during the visit, but Pas are not authorized to perform face-to-face encounter
  - Statutory restriction under Section 1814(a)((7)(D)(i)
- “Nothing in statute or regulation precludes a hospice designated attending physician from furnishing services via telehealth”
The statute is silent as to whether a face-to-face encounter solely for the purpose of Medicare hospice recertification (meaning there is no direct patient care) could be conducted via telecommunications technology by the hospice physician or NP. Given that a face-to-face visit solely for the purpose of recertification for Medicare hospice services is considered an administrative requirement related to certifying the terminal illness as required in section 1814(a)(7)(D)(i) of the Act, we believe that such visit could be performed via telecommunications technology as a result of the PHE for the COVID-19 pandemic.
GENERAL HOSPICE CARE

HH. Hospice

1. **Question:** Can hospices furnish services using telecommunications technology during the PHE for the COVID-19 pandemic?

   **Answer:** Yes. Hospices are able to furnish services using telecommunications technology during the PHE when a patient is receiving routine home care. This can include telephone calls (audio only or TTY), two-way audio-video telecommunications technology that allow for real-time interaction between the patient and clinician (e.g., FaceTime, Skype), and remote patient monitoring. It would be up to the clinical judgment of hospice as to whether such technology can meet the patient’s/caregiver’s/family’s needs and the use of technology should be included on the plan of care for the patient and family.

   New: 5/1/20
Questions?

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