

Telemedicine Hospital Outpatient Billing

UPDATED INFO

See yellow highlights for updated content from previous published version.

Background

The April 30, 2020 Interim Final Rule (IFR) finally explained how HOPDs are to use the expanded hospital location waiver to bill for many services that are often provided in provider-based clinics or departments.

“For purposes of enabling greater hospital flexibility, and, in particular, enabling hospitals to rapidly develop temporary expansion sites for patient care, we are temporarily adopting an expanded version of the extraordinary circumstances relocation policy during the COVID-19 PHE to include on-campus PBDs that relocate off-campus during the COVID-19 PHE for the purposes of addressing the COVID-19 pandemic.

Our policy has historically applied only to excepted off-campus departments that relocate to a different off-campus location for extraordinary circumstances outside of the hospital’s control, that submit an extraordinary relocation exception request to their CMS Regional Office, and for which the CMS Regional Office evaluates and approves the request.

However, on-campus departments that relocate on or after March 1, 2020 through the remainder of the PHE for the purposes of addressing the COVID-19 pandemic may also seek an extraordinary circumstances relocation exception so that they may bill at the OPSS rate, as long as their relocation is not inconsistent with the state’s emergency preparedness or pandemic plan.”

“Using the process outlined below, both **excepted off-campus and on-campus** PBDs may relocate to off-campus locations during the COVID-19 PHE and begin furnishing and billing for services under the OPSS in the new location prior to submitting documentation to the Regional Office (RO) to support the extraordinary circumstances relocation request.”

“We note that, during the COVID-19 PHE, a patient’s home would be considered a PBD of the hospital when the patient is registered as a hospital outpatient (as discussed in section II.F. of this CMS-5531-IFC 43 IFC) and is receiving covered OPD services from the hospital.”¹

In many cases, hospitals provide hospital outpatient therapy (including behavioral health), education, and training services that are furnished by hospital-employed counselors or other licensed professionals.

The IFR states “examples of these services include psychoanalysis, psychotherapy, diabetes self-management training, and medical nutrition therapy. With few exceptions, the Medicare statute does not have a benefit category that would allow these types of professionals (for example, counselors, nurses, and registered dietitians) to bill Medicare directly for their services. These services can, in many cases, be billed by providers such as hospitals under the OPSS or by physicians and other practitioners as services incident to their professional services under the PFS.”

“Outpatient therapy, education, and training services require communication and interaction. Facility staff can effectively furnish these services using telecommunication technology and, unlike many hospital services, the clinical staff and patient are not required to be in the same location to furnish them. We have already stated that section 1135 blanket waivers in effect during the COVID-19 PHE allow the hospital to consider the beneficiary’s home, and any other temporary expansion location operated by the hospital during the COVID-19 PHE, to be a PBD of the hospital, so long as the hospital can ensure the locations meet all of the conditions of participation, to the extent not waived. In light of the need for infection control and a desire for continuity of behavioral health care and treatment services, we recognize the ability of the hospital’s clinical staff to continue to deliver these services even when they are not physically located in the hospital. Provided a hospital’s clinical staff is furnishing hospital outpatient therapy, education, and training services to a patient in the hospital (which can include the patient’s home so long as it is provider based to the hospital), and the patient is registered as an outpatient of the hospital, we will consider the requirements of the regulations at § 410.27(a)(1) to be met.”

On page 40 of the IFR CMS instructs all hospitals that relocate **excepted on- or off-campus** PBDs to off-campus locations in response to the COVID-19 PHE to notify their CMS Regional Office by email of:

- ✓ Their hospital's CMS certification number (CCN);
- ✓ The address of the current PBD;
- ✓ The address(es) of the relocated PBD(s);
- ✓ The date which they began furnishing services at the new PBD(s);
- ✓ A brief justification for the relocation and the role of the relocation in the hospital's response to COVID-19; and
- ✓ An attestation that the relocation is not inconsistent with their state's emergency preparedness or pandemic plan.

CMS expects hospitals to include in their justification for the relocation why the new PBD location, including instances where the relocation is to the patient's home, is appropriate for furnishing covered outpatient items and services.

According to the IFR to the extent that a hospital may relocate to an off-campus PBD that otherwise is the patient's home, only one relocation request during the COVID-19 PHE is necessary. In other words, the hospital would not have to submit a unique request each time it registers a hospital outpatient for a PBD that is otherwise the patient's home; a single submission per location is sufficient.

Hospitals must send this email to their CMS Regional Office (RO) within **120 days** of beginning to furnish and bill for services at the relocated on- or off-campus PBD.

This statement in the IFR has been subject to two different interpretations since its release. On one hand it is read as requiring only one general notification to the MAC that the hospital intends to expand to patient's homes. On the other hand, it may be read as requiring only one notification per patient regardless of how many times outpatient visits occur at the patient's home.

On a CMS provider call on Thursday, May 7, 2020 the representative responded to this question by indicating that one notice per patient was required. Furthermore, they referred to the 120-day period hospitals have to notify the MAC of services at a patient's home and could use a roster indicating the patient's name and address submitted monthly instead of submitting them as patient's are registered.

In the event hospitals are still uncertain as to the action to be taken nThrive recommends calling the MAC for further clarification and instruction.

nThrive has also submitted this question in writing to CMS for further clarification and will provide an update if this instruction changes.

The relocation or partial relocation of an excepted PBD for the extraordinary circumstance of the COVID-19 PHE could involve a single excepted PBD that relocates (or partially relocates) to a patient's home (for purposes of furnishing a covered OPD service), which under the Hospitals without

Walls initiative, can be provider-based to the hospital during the COVID-19 PHE.

The hospital will bill services as they would have pre-PHE as due to the expansion the services are being delivered in an expanded location of the hospital. Hospitals with on-campus and excepted off-campus PBDs that "relocate" due to the COVID-19 PHE in a manner that is not inconsistent with their state's emergency preparedness or pandemic plan should append Modifier PO, *Excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, to OPSS claims for services furnished at the relocated PBDs. This modifier indicates a service that is provided at an excepted off-campus PBD and is paid the OPSS payment rate.

If the relocation is denied by the RO under the extraordinary circumstances policy or the hospital chooses not to submit patient names and addresses to the MAC, and the hospital did not bill for them using Modifier PN, *Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, any claims billed under the OPSS in the new location would need to be reprocessed as having been billed by a non-excepted PBD and will instead be paid the PFS-equivalent rate.

Non-excepted off-campus departments will continue to be non-excepted during the COVID-19 PHE, even if they relocate, and thus, will continue to be paid the PFS-equivalent rate. They do not need to follow the process outlined above for relocation approval since they are already, and will continue to be, non-excepted.

CMS provides a list of services (List of Hospital Outpatient Services and List of Partial Hospitalization Program Services Accompanying the 4/30/2020 IFC) that may be provided in the patient's home when it is an expanded location of the hospital. They indicate this is not an all-inclusive list and provides examples of services to educate the public. This list may be found at: <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.

CMS cautions that when these services are provided by clinical staff of the physician or other practitioner and furnished incident to their professional services, and are not provided by staff of the hospital, the hospital would not bill for the services. The physician or other practitioner should bill for such services incident to their own services and would be paid under the physician fee schedule (PFS).

Provisions for Partial Hospitalization Programs (PHP) may also be found at this site. The following types of services, to the extent they were already billable as PHP services in accordance with existing coding requirements prior to the COVID-19 PHE, can now be furnished to beneficiaries by facility staff using telecommunications technology during the COVID-19 PHE using CPT codes common to the service²:

- ✓ Individual psychotherapy (90785, 90832-90834, 90836-90838, 90845)
- ✓ Patient education (G0177)
- ✓ Group psychotherapy (90846, 90847, 90849, G0410, G0411)

Because of the intensive nature of PHP, CMS expects PHP services to be furnished using telecommunications technology involving both audio and video. However, CMS recognizes that in some cases beneficiaries might not have access to video communication technology:

“In order to maintain beneficiary access to PHP services, only in the case that both audio and video are not possible can the service be furnished exclusively with audio. To be clear, services that require drug administration cannot be furnished using telecommunications technology.”

On page 53 of the IFR services that must be delivered face-to-face are also discussed.

“Hospitals also provide services that are furnished by clinical staff under a physician’s or qualified NPP’s order that do not require professional work by the physician or qualified NPP, and thus, are billed only under the OPPTS when furnished by the hospital and are not separately billable under the PFS.

Wound care, chemotherapy administration, and other drug administration are examples of these types of services.

We note that while surgical services also fall under this category, we would not anticipate that they would be furnished in a home that becomes provider-based to the hospital, due to infection control and operating room requirements. In addition, there are several other hospital outpatient therapeutic services that require the hospital’s clinical staff’s presence to furnish the service.

The current section 1135 blanket waivers in place during the COVID-19 PHE allow the patient’s home to be considered an outpatient PBD of the hospital. With a primary goal of infection control and understanding that hospitals must meet the conditions of participation, to the extent not waived during the COVID-19 PHE, we are making the public aware of the flexibilities that exist during the COVID-19 PHE that enable hospitals to furnish these clinical staff services in the patient’s home as an outpatient PBD and to bill and be paid for these services as HOPD services when the patient is registered as a hospital outpatient.

Because these services have to be provided in person by clinical staff, these services cannot be furnished by telecommunication technology by the hospital. In these instances, hospital clinical staff must be physically present in the patient’s home or other temporary expansion location that is provider based to the hospital to furnish the hospital outpatient therapeutic service.”

With these long-awaited instructions hospitals began to implement charge capture strategies. Unfortunately, a new CMS FAQ published on May 27, 2020 brought confusion back to the discussion.³

Question: Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?

Answer: Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the “-95” modifier applied to the service line. This includes:

- Hospital – 12X or 13X (for hospital outpatient therapy services);
- Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B physical therapy (PT)/occupational therapy (OT)/speech-language pathology (SLP) services to their own long-term residents);
- Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);
- Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services);
- Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT & SLP as well as OT services); and
- Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care).

New: 5/27/20

The language used in this Q&A seemed to follow the instruction for independent therapists that are permitted to bill actual telehealth services as specified on the list of eligible telehealth services. However, the inclusion of 12x and 13x claim types for hospital outpatient billing and the instruction to report Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and*

Video Telecommunications System, which was previously limited to professional billing brought out many questions during the June 2, 2020 CMS “office hours” call.

On this call CMS clarified that they have further expanded the options outpatient hospitals have for reporting therapy services. Hospital outpatient therapy departments may either:

1. Notify the Medicare Regional Office of the expansion of their walls to include the patient’s home and then follow the instructions for billing using either Modifier PO or PN depending upon the hospital’s decision to report the patient addresses.
2. Report the therapy services found on the list of eligible telehealth services with Modifier 95.

If option number two is elected providers should take note that this method is limited to only those therapy services found on the list of eligible telehealth services which includes: Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, and 92507).

A complete list of all Medicare telehealth services can be found here: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

All other outpatient services rendered using remote telecommunication equipment are to be reported using the patient’s home as an expansion of the hospital’s wall as described under option number one.

In the April IFR CMS acknowledged that when a physician or practitioner who ordinarily practices in the HOPD furnishes a telehealth service to a patient who is located at home, the hospital would often still provide some administrative and clinical support for that service. For hospitals that have met the requirements to temporarily expand their walls billing **Q3014, Telehealth originating site facility fee**, becomes applicable. Revenue code 780, *Telemedicine – General*, is used to report HCPCS Q3014.

“When a registered outpatient of the hospital is receiving a telehealth service, the hospital may bill the originating site facility fee to support such telehealth services furnished by a physician or practitioner who ordinarily practices there. **This includes patients who are at home, when the home is made provider-based to the hospital** (which means that all applicable conditions of participation, to the Hospital Services Accompanying a Professional Service Furnished Via Telehealth extent not waived, are met), under the current waivers in effect for the COVID-19 PHE.

More specifically, when a telehealth service is furnished by a practitioner located at a distant site to a patient who is located in the HOPD, the hospital is presumed to provide administrative and clinical support resources. In such circumstances, section 1834(m)(2)(B) of the Act allows for an originating site facility fee to be paid to the hospital. Section 1834(m)(2)(B)(ii) of the Act further provides that no facility fee shall be paid to an originating site described in paragraph (4)(C)(ii)(X) (that is, the home). However, as described throughout this section, the patient’s home may be considered a PBD of the hospital during the COVID-19 PHE if other applicable requirements (including the non-waived conditions of participation) are met. As noted above, because the home is not a traditional PBD, and because there are interactions with other types of providers or suppliers who may furnish services in the home, but not in the “hospital,” we note that hospitals should only furnish hospital outpatient services to a patient (who is registered as a hospital outpatient) after the patient’s home has been made provider-based to the hospital for the provision of such services. In that event, the home would be serving as a PBD of the hospital, and as the originating site for the telehealth service furnished by a physician or practitioner located at a distant site.

Therefore, during the COVID-19 PHE, when telehealth services are furnished by a physician or practitioner who ordinarily practices in the HOPD to a patient who is located at home or other applicable temporary expansion location that has been made provider based to the hospital, we believe it would be appropriate to permit the hospital to bill and be paid the originating site facility fee amount for those telehealth services, just as they would have ordinarily done outside of the COVID-19 PHE in this circumstance.”

During the June 2, 2020 “office hours” call CMS also reinforced guidance previously provided in response to questions regarding the billing of telehealth services to inpatients. In this guidance CMS stated that although remote telecommunication equipment was used to “visit” the patient in the hospital while adhering to infection control restrictions that limit the number of staff making contact with the patient, it was not considered telehealth as both the practitioner and the patient were at the hospital.

This logic is also being applied to practitioners “visiting” the patient at home from a hospital outpatient provider-based clinic as shown in the June 16, 2020 updates to the CMS FAQ.⁴ If the hospital has expanded its walls to include the patient’s home and the physician is at a hospital location, they are both considered to be on the hospital’s campus and the visit is not considered telehealth. Rather than billing the

service as a telehealth visit it would be billed as if the patient was seen in the clinic. This allows the hospital to split bill the technical component of an E/M visit with G0463.

Question: When hospital clinical staff furnish a service using telecommunication technology to the patient who is a registered outpatient of the hospital and the hospital makes the patient's home provider-based to the hospital as a temporary expansion site, should the hospital bill using the telehealth modifier (modifier 95)?

Answer: No. In this situation the hospital is furnishing an outpatient hospital service, not a telehealth service, to a patient in a temporarily relocated department of the hospital as discussed at 85 FR 27560. Accordingly, the hospital would bill as it ordinarily would bill and would include the DR condition code or CR condition code (as applicable) on the claim. If the situation involves a relocation of an on-campus or excepted off-campus provider-based department to an off-campus hospital location, the hospital would bill using the PO modifier (service provided at an excepted off-campus provider-based department) only if the hospital requests an extraordinary circumstances relocation request within 120 days of the date the temporary expansion site is made provider-based to the hospital; otherwise, the hospital would append the PN modifier (service provided at a non-excepted off-campus provider-based department) to claims from the relocated hospital location. New: 6/16/20

However, if the practitioner is at a remote site not considered to be the hospital campus then the hospital is limited to billing the originating site fee using Q3014.

Both G0463 and Q3014 would not be billed together.

In addition to all the provisions outlined CMS also confirmed that the provisions in the April 30, 2020 IFR have been made retroactive to March 1, 2020, unless otherwise noted.

As these services are being provided under the 1135 waiver hospitals should also apply Condition code DR, *Disaster related*.

Guidance

- ✓ Confirm services to be provided remotely would normally be provided at an on-campus or excepted off-campus location of the hospital.
- ✓ Determine which outpatient billing method is appropriate and to be utilized for therapy versus other outpatient services.
- ✓ For option one, send the required information via email to the CMS Regional Office serving the hospital to request expansion of the hospital's outpatient locations to include the patient's home.
 - Add Modifier PO, *Excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, to qualified services and release claims to Medicare MAC.
 - If services were rendered by a non-excepted department or the request to expand under the current waiver is denied, apply Modifier PN, *Excepted service provided at an off-campus, outpatient, provider-based department of a hospital*, to the services and release claims to the Medicare MAC.
 - The hospital chooses not to provide notice to the MAC of the intent to expand and provide the name and address of the patient.
- ✓ Apply Condition code DR to all claims for services provided to patients at home.
- ✓ Implement a charge capture process
 - Split billing when both the practitioner and the patient are at the hospital.
 - Origination site fees when services that would have been provided at the hospital pre-PHE are provided by a distant site provider to patients at home.
- ✓ Determine if non-Medicare payers will accept the provision of services remotely or if other guidelines are in place.



Sources

1. <https://www.cms.gov/files/document/covid-medicare-and-medicaid-ifc2.pdf>
2. Medicare Claims Processing Manual, Chapter 4, Section 260.1.
3. <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>
4. <https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf>. Section G. Hospital Outpatient – Locations off of Hospital Campus. ■