Keeping up with COVID-19

Webinar Series

Q&A

April 9, 2020

Revenue Enhancement Through Patient Care Improvement During and After the Public Health Emergency

Thank you for your questions. nThrive has addressed many of the issues in the coding updates and protocols found on www.nthrive.com/covid19 – **our new nThrive COVID-19 portal**.

The site includes a link to our webinars, summary guidelines for CMS updates, quick reference guides, videos, summary overviews of nThrive protocols and business continuity plans, access to our thought leadership webinars and an overview of the business continuity and business recovery solutions to help our clients during this challenging time.

The quick reference guides currently available and specific to telehealth include documentation and consent requirements, and both professional and facility coding.

nThrive is providing updated CARES Act information as it becomes available. An Interim Final Rule (IFR) is soon to be published that impacts the guidance to be received from CMS. nThrive is working diligently to share this information and update previous information through these coding updates on the nThrive portal. We recommend accessing these documents for details on how to report the services.

CMS MLN Bulletin with FAQ

Many participants have asked the same or very similar questions, and we have grouped these and provided a singular response, following.

Click below for more info

Claim Codes and Modifiers

Lab Testing and Diagnosis Coding

RHC and CAH Telehealth Services

Telehealth for Hospital and Therapy Services

TCM and CCM Services

Additional Post Webinar Q&A

For the remaining questions, nThrive directs participants to the CMS MLN updated Frequently Asked Question (FAQ) page that was updated April 9, 2020. Answers to these questions may be found at: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf.

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Claim Codes and Modifiers

As of this date, the following guidance is applicable:

Modifier CS

April 7, 2020 CMS released an MLN Special Edition that included an article that, according to the title, addressed the waiving of copays and deductibles. On the surface, this may not have captured the interest of those preparing claims data. However, the article directs providers to utilize an additional modifier to indicate that the line-item service was related to the assessment for, or diagnosis of, COVID-19 whether it results in testing or not.

This change is retroactive to March 18, 2020 and continues through the end of the PHE. These services might have been provided face-to-face, by telehealth or by the Lab. Regardless, Modifier *CS, Cost Sharing Waived,* must be applied.

Providers that have already submitted claims on or after March 18, 2020 must take additional action:

- For professional claims, physicians and practitioners who did not initially submit claims with the Modifier CS must notify their Medicare Administrative Contractor (MAC) and request to resubmit applicable claims with dates of service on or after 3/18/2020 with the Modifier CS to get 100% payment.
- For institutional claims, providers, including hospitals, CAHs, RHCs, and FQHCs, who did not initially submit claims with the Modifier CS must resubmit applicable claims submitted on or after 3/18/2020, with the Modifier CS to visit lines to get 100% payment.

Modifier CS is to be applied in addition to any other modifiers or condition codes that may also be required.

Modifier 95

Telehealth services require technology that includes both audio and video communication. As such professional providers are directed to apply Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System,* to the line item service related to a telehealth service. (CMS Special Edition Bulletin, April 3, 2020.)

During the Open-Door Forum calls the week of April 6, 2020, which nThrive has been monitoring, CMS indicated that Modifier 95 may also be reported on hospital facility UB-04 claims as well. This would seem to eliminate any need to use Revenue code 0278, *Telehealth Services*. However, we caution hospitals to be alert for further guidance from both CMS and/or their individual MAC as the provisions of the CARES Act and IFR are operationalized.

Modifier CR

Modifier CR, catastrophe/disaster related, is used in relation to Part B items and services for **both institutional and non-institutional billing**. Non-institutional billing, i.e., claims submitted by "physicians and other suppliers," are submitted either on a professional paper claim form CMS-1500 or in the electronic format ANSI ASC X12 837P or – for pharmacies – in the NCPDP format.

Modifier CR is historically considered no longer discretionary but is mandatory for applicable HCPCS codes on any claim for which Medicare Part B payment is conditioned **directly or indirectly** on the presence of a "formal waiver." However, late Friday, April 3, 2020 CMS released a corrective bulletin indicating that Modifier CR is not to be used on 1500 professional claims for telehealth services.[1] Rather CMS states, professional providers "should report the place of service equal to what it would have been had the service been furnished in-person; and Modifier 95, indicating that the service rendered was actually performed via telehealth."

Modifier QT

Method II Critical Access Hospitals (CAH) where the practitioner has reassigned their benefits to the CAH submit the appropriate HCPCS code for the covered telehealth service with Modifier GT, *Via interactive audio and video telecommunication systems*.

Point of Service Code

April 3, 2020 CMS released a corrective bulletin indicating that professional providers "should not report Place of Service code 02 but report the place of service equal to what it would have been had the service been furnished in-person." (CMS Special Edition Bulletin, April 3, 2020)

Condition Code DR

Condition code DR, *disaster related*, requires it to be "used to identify claims that are or may be impacted by specific payer/health plan policies related to a national or regional disaster."

Condition code DR is used only for institutional billing, i.e., claims submitted by providers on an institutional paper claim form CMS-1450/UB-04 or in the electronic format ANSI ASC X12 837I. Effective August 31, 2009, use of the DR condition code will be mandatory for any claim for which Medicare payment is conditioned **directly or indirectly** on the presence of a "formal waiver."

The use of Condition Code DR and Modifier CR indicates not only that the item/service/claim was affected by the emergency/disaster, but also that the provider has met all of the requirements CMS has issued to Medicare contractors regarding the emergency/disaster.[2]

According to the Medicare Claims Manual, the "DR condition code is used at the claim level when all of the services/items billed on the claim are related to the emergency/disaster."[3]

Additional details and examples can be found in the coding updates published on the nThrive COVID-19 Coronavirus Portal.

Condition Code 44

CMS is waiving certain requirements which address the statutory basis for hospitals, and includes the requirement that hospitals participating in Medicare and Medicaid must have a utilization review plan that meets specified requirements.

CMS is waiving the entire Utilization Review (UR) condition of participation which requires that a hospital must have a UR plan with a UR committee that provides for a review of services furnished to Medicare and Medicaid beneficiaries to evaluate the medical necessity of the admission, duration of stay, and services provided. These flexibilities may be implemented so long as they are not inconsistent with a state's emergency preparedness or pandemic plan. The intent of removing these administrative requirements is to allow hospitals to focus more resources on providing direct patient care. (https://www.cms.gov/files/document/qso-20-13-hospitalspdf.pdf-2)

In some instances, patients may have initially been admitted as an inpatient and after screening by the UR/Case Management staff and review by a physician, the patient may have been converted to an observation status. In such instances, the hospital should review any guidance published by the MAC related to Condition Code 44 billing requirements to ensure compliance.

On a CMS Open Door call on April 9, 2020, a question was asked by a participant if any of the waivers affected the assignment of Condition code 44 or its reimbursement impact. CMS responded that the waivers did not and, in those instances where the hospital could identify that it was appropriate to report Condition code 44, that they should do so.

Additional details regarding these topics may be found in the coding updates on the nThrive COVID-19 Coronavirus Portal. ■

Lab Testing and Diagnosis Coding

As of this date, the following guidance is applicable. See nThrive Quick Reference Guide: Diagnostic Testing.

Laboratory Testing

Payer and test methodology determine the testing code submitted. If unknown, the hospital may need to contact their laboratory vendor to determine if a CDC test methodology is being used.

The following may be reported once per specimen obtained:

Medicare CDC Test Methodology: U0001, *CDC 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel, for use with CDC developed testing*

Medicare non-CDC Test Methodology: U0002, *2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets), for non-CDC developed testing (e.g., Hospital specific in-house developed testing)*

Non-Medicare Nucleic Acid Amplified Probe Methodology: 87635, *Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)(Coronavirus disease [COVID-19]), amplified probe technique*

Diagnosis Coding

Prior to April 2, 2020 the CDC interim coding guidelines were in effect (https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf).

Confirmed cases of Coronavirus infection:
No longer report ICD-10 code B97.29, *Other coronavirus as the cause of diseases classified elsewhere*

Report Primary Diagnosis Code U07.1, *COVID-19-nCoV acute respiratory disease* and any Secondary ICD-10 code as applicable

Example: For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes U07.1, COVID-19-nCoV acute respiratory disease and J12.89, Other viral pneumonia

Possible Exposure to COVID-19: Z03.818, *Encounter for observation for suspected exposure to other biological agents ruled out*. Report when patients were possibly exposed to COVID-19 which has been ruled out.

Confirmed Exposure to COVID-19: Z20.828: *Contact with and (suspected) exposure to other viral communicable diseases*. Report when patients have actual exposure to COVID-19 without development of the disease.

Unconfirmed COVID-19: A diagnosis of "suspected", "probable", or "possible" COVID-19 should be assigned a code for the sign/symptom explaining the reason for the encounter such as fever or cough.

The ICD-10 guidelines released effective April 1, 2020 do not differ from the interim guidelines released by the CDC prior to this date.

April 1, 2020 – December 31, 2020 ICD-10 Guidelines:

Exposure to COVID-19

For cases where there is a concern about possible exposure to COVID-19, but it is ruled out after evaluation, assign code Z03.818, Encounter for observation for suspected exposure to other biological agents ruled out.

For cases where there is an actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests negative or the test results are unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. If the exposed individual tests positive for the COVID-19 virus, see guideline a).

e) Screening for COVID-19

For asymptomatic individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or negative, assign code Z11.59, Encounter for screening for other viral diseases. For individuals who are being screened due to a possible or actual exposure to COVID-19, see guideline d).

If an asymptomatic individual is screened for COVID-19 and tests positive, see guideline(g).

f) Signs and symptoms without definitive diagnosis of COVID-19

For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:

• R05 Cough

• R06.02 Shortness of breath

• R50.9 Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to someone who has COVID-19, assign Z20.828, contact with and (suspected) exposure to other viral communicable diseases, as an additional code. This is an exception to guideline I.C.21.c.1, Contact/Exposure.

g) Asymptomatic individuals who test positive for COVID-19

For asymptomatic individuals who test positive for COVID-19, assign code U07.1, COVID-19. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

CMS COVID-19 Specimen Collection

To identify and reimburse specimen collection for COVID-19 testing, CMS established two HCPCS codes, effective with line item date of service on or after March 1, 2020. The following codes are billable by clinical diagnostic laboratories:

- G2023 - *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), any specimen source*
- G2024 - *Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), from an individual in a skilled nursing facility or by a laboratory on behalf of a home health agency, any specimen source*

Medicare will pay when laboratories can send trained technicians to a beneficiary's home, including a nursing home, to collect a sample for COVID-19 diagnostic testing.

- Medicare will pay a collection fee and the travel cost.
- The nominal specimen collection fee for COVID-19 testing for homebound and non-hospital inpatients generally is $23.46 and for individuals in a SNF or whose samples are collected by a laboratory on behalf of an HHA is $25.46.

If a patient is already receiving Medicare home health services, the home health nurse, during an otherwise covered visit, could obtain the sample to send to the laboratory for COVID-19 diagnostic testing.

If a visiting nurse has an otherwise covered RHC or FQHC visit, they can obtain a sample to send to the laboratory for COVID-19 diagnostic testing.

- Any RHC/FQHC visiting nurse service solely to obtain a nasal or throat culture would not be considered a nursing service because it would not require the skills of a nurse to obtain the culture as the specimen could be obtained by an appropriately-trained medical assistant or laboratory technician.[4]

A full discussion of these topics, as well as the use of Modifier CS, *Cost Sharing*, may be found on the nThrive portal. However, providers should be aware that on April 7, 2020 CMS released an MLN Special Edition bulletin addressing the waiving of copays and deductibles.

The article directs providers to utilize an additional modifier to indicate that the line-item service was related to the assessment for, or diagnosis of, COVID-19 whether it results in testing or not. This change is retroactive to March 18th and continues through the end of the PHE. These services might have been provided face-to-face, by telehealth or by the Lab. Regardless, Modifier CS, *Cost Sharing Waived*, must be applied.

Initially, the article indicates that the waiver of cost-sharing referred to medical visits for the HCPCS evaluation and management categories listed when an outpatient provider, physician, or other providers and suppliers that bill Medicare for Part B services orders or administers COVID-19 lab test U0001, U0002 or 87635. However, the article goes on to state "services that result in an order for or administration of a COVID-19 test; are related to furnishing or administering such a test **or to the evaluation of an individual for purposes of determining the need for such a test**" are subject to the waiver of cost-sharing.[5] This would seem to indicate that if the visit relates to the assessment of COVID-19 symptoms regardless of whether the patient is ultimately tested that cost-sharing would not be applicable. ■

RHC and CAH Telehealth Services

In general, CMS has expanded the list of telehealth services that may be provided. The full list may be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

The CARES Act waived the Section 1834(m) restriction on FQHCs and RHCs that prohibits them from serving as distant sites. "Specifically, during the emergency period, FQHCs and RHCs will be able to serve as distant sites to provide telehealth services to patients in their homes and other eligible locations. The legislation will reimburse FQHCs and RHCs at a rate that is similar to payment for comparable telehealth services under the physician fee schedule." (https://www.aha.org/special-bulletin/2020-03-26-senate-passes-coronavirus-aid-relief-and-economic-security-cares-act)

Although CMS has stated that RHCs will be paid an amount comparable to that found on the physician fee schedule, an actual mechanism for submitting these claims has not been identified. CMS has indicated that additional information will be forthcoming and nThrive recommends holding RHC claims until further direction from CMS is received.

Virtual services are not considered to be Telehealth. Reporting these services such as G2012, *Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating 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; 5-10 minutes of medical discussion*, Effective 1/1/2019, may be reported as follows:

- If provided through the CAH by a physician in a provider-based clinic, bill G2012 for Virtual check-in visits under CAH Method II using Revenue Code 96x. Modifier GT is not required as this is not considered a telehealth code.
- If provided through the RHC; virtual communication services furnished by RHCs and FQHCs on or after January 1, 2019, are paid at the average of the national non-facility PFS payment rate for HCPCS code G2012 (communication technology-based services), and HCPCS code G2010 (remote evaluation services), **when the virtual communication HCPCS code, G0071, is on an RHC** or FQHC claim, either alone or with other payable services. The payment rate for HCPCS code G0071 is updated annually based on the PFS amounts for these codes. (Reference: Pub. 100-02, Chapter 13, Section 240)

Method I Critical Access Hospitals (CAH) have not been specifically addressed. This may be as professional services are billed separately on a 1500 claim form just as an OPPS hospital would bill. nThrive recommends referencing the professional billing guides and updates found on the nThrive COVID-19 Coronavirus Portal. ■

Telehealth for Hospital and Therapy Services

In general, CMS has expanded the list of telehealth services that may be provided. The full list may be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.

This added certain physical medicine codes typically provided by PT, OT and Speech Therapy. However, CMS did not add the therapists to the list of eligible distant site providers. This issue was brought up in various Open-Door Forum calls with CMS. They indicated they were working to resolve the issue and gave no objection to those listeners who inquired about, or stated that they were, rendering the services in order to benefit their patients and were holding claims until the issue was resolved.

Diabetes Self-Management Training (DSMT) and Medical Nutrition Therapy (MNT) as telehealth services are not dependent upon a waiver. These services were already on the list of eligible telehealth services prior to the Public Health Emergency (PHE). The dieticians and nutritional health providers were also already on the list of acceptable distant site providers. Subsequently, these services that

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE[E]	Patient Relationship with Qualified Nonphysician Health Care Professional
MEDICARE TELEHEALTH VISITS[A] 	Diabetes Self-Management Training and Medical Nutrition Therapy.	Common telehealth services include: ✓ **97802** (Medical nutrition indiv init) ✓ **97803** (Medical nutrition indiv subsq) ✓ **97804** (Medical nutrition group) ✓ **G0108** (Diab manage trn per indiv) ✓ **G0109** (Diab manage trn group) ✓ **G0270** (MNT subs tx for change dx)	For new[B] or established patients.
VIRTUAL CHECK-IN[D] 	A brief (5-10 minutes) check in with a qualified nonphysician healthcare professional[C] via telephone or other approved telecommunications device to decide whether an office visit or service is needed, or a remote evaluation of recorded video and/or images submitted by an established patient.	✓ **G2010** (remote evaluation of recorded video) ✓ **G2012** (brief communication tech-based service)	For established patients.
E-VISITS[D] 	A communication between a patient and a qualified nonphysician health care professional through an online patient portal.	Online assessment: ✓ **G2061** (5-10 minutes) ✓ **G2062** (11-20 minutes) ✓ **G2063** (21+ minutes)	For established patients including up to 7 days cumulative time.
TELEPHONE ASSESSMENT & MANAGEMENT 	A communication between a patient and a qualified nonphysician health care professional using the telephone.	Telephone assessment and management: ✓ **98966** (5-10 minutes) ✓ **98967** (11-20 minutes) ✓ **98968** (21+ minutes)	For new or established patients.

Notes

A Review state-specific Medicaid and third-party insurance plans to determine whether services are covered, and which codes are recognized.

B To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

C Qualified nonphysician health care professionals are currently identified in Sections 1842(b)(18)(C) and 1834(m)(4)(E) of the Social Security Act. [physician assistant, nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologists, clinical social workers, and registered dietitians or nutrition professionals]. With the implementation of the CARES Act, LCSWs, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists were included for virtual check-ins and e-visits; expect additional information regarding billing requirements for the therapies.

D Providers may use popular *non-public facing* applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype. Current waivers allow this service for both new and established patients even though the codes are defined as established.

E Services are reported on institutional claims: Report the appropriate CPT/HCPCS; Report Condition code DR, *disaster related,* on the claim (other than for DSMT/MNT) as these other services are provided under formal waiver; Report Modifier CR, *catastrophe/disaster related,* for any services directly related to COVID-19; report Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*. Apply Modifier CS, *Cost Sharing Waived,* to services with DOS 3/18/20 through end of PHE related to assessment for or diagnosis of COVID-19 whether it results in testing or not.

traditionally have been provided in a classroom can be converted to a telehealth mechanism that includes both audio and video capabilities. The same charge and HCPCS codes would be submitted as they were when the patient came to the classroom.

The remaining element for providing services on the eligible telehealth list by eligible distant site providers in outpatient hospital departments was how to convey the service is now being rendered via telehealth. As a modifier was not available for facility claims for this purpose, nThrive initially recommended use of Revenue code 0780, *Telemedicine*. However, just this week CMS has held several Open-Door Forum calls where they answered participant questions. One such question was posed regarding hospital use of Modifier 95, *Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System*.

CMS responded that Modifier 95 may be used on an eligible facility telehealth claim to indicate that the service was provided as required using both audio and video capability.

The virtual and telephone services shown on the table above are not considered telehealth and therefore have other requirements of the electronic technology that may be used. During this week's Open-Door Forum calls CMS indicated that providers could obtain consent from the patient for the physician practice to initiate any future contact for those services defined as "patient initiated."

In addition, during the April 8, 2020 call CMS indicated that those services not currently covered or reported under OPPS will be updated in upcoming rate tables and that providers may need to hold claims until the systems are updated to process and pay these claims. See nThrive Quick Reference Guide: Telehealth Facility Coding.

Finally, many hospital providers have asked if the telehealth visits rendered by physicians or extenders in hospital or health system owned practice settings are subject to split billing as they did the face-to-face visits.

To date, everything CMS has stated or published would indicate that this is not the case and only the professional component may be billed. However, on the Open-Door Forum call on Wednesday, April 8, 2020 this was brought up by several participants and the CMS members on the call asked that the question be submitted in writing for further consideration.

In addition, HCPCS Q3014, *Telehealth originating site facility fee*, may not be reported by a facility unless the patient is present at the location.

nThrive will provide any future directives regarding this subject through the coding updates published on the nThrive COVID-19 Coronavirus Portal. ■

TCM and CCM Services

Monthly Billing Requirement

Transitional Care Management (TCM) services are intended to assist patient transition successfully from a hospital stay back to a community setting. CMS reduced some of the administrative burdens associated with billing TCM services, as part of the 2020 Physician Fee Schedule Final Rule (2020 Final Rule). One such example is the elimination of the prohibition on billing certain services furnished during the 30-day period covered by TCM. Notably, physicians can now bill for Chronic Care Management (CCM) and Care Plan Oversight during the same period as TCM.

In the 2020 Final Rule, CMS stated, "We believe that both CPT codes 99490 and the new 99491 should be added to the list of care management codes that can be billed concurrently with TCM when relevant and medically necessary."

CMS further stated that they "continue to believe that revising the billing requirements and allowing TCM codes to be billed concurrently with codes currently restricted will help to achieve our goal and may result in other payers implementing similar changes."

The requirements for 20 minutes of monitoring must be met for both CCM and TCM in that 30-day post hospitalization period in order to bill both codes. https://www.federalregister.gov/d/2019-24086/p-1178

Face-to-Face Requirement

Codes 99495 and 99496 are used to report transitional care management services (TCM). TCM commences upon the date of discharge and continues for the next 29 days. TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non- face-to-face services that may be performed by the physician

or other qualified health care professional and/or licensed clinical staff under his/her direction. The list of approved telehealth services includes transitional care management services with moderate medical decision and high medical decision complexity.[6]

The face-to-face physician visit component of the transitional care management is billed rather than the physician office visit (e.g. CPT code 99214). Should the patient be readmitted to the hospital or die during the 30-day TCM period, the physician would be the office visit E/M. Given the fact that the transitional care management is billed instead of the office visit, the face-to-face office visit is simply a component of the overall TCM services.

The transitional care services are for a patient whose medical and/or psychosocial problems require moderate or high complexity medical decision making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domiciliary, rest home, or assisted living). TCM commences upon the date of discharge and continues for the next 29 days. TCM is comprised of one face-to-face visit within the specified timeframes, in combination with non- face-to-face services that may be performed by the physician or other qualified health care professional and/or licensed clinical staff under his/her direction. ■

Additional Post Webinar Q&A

Q. How to best position ourselves now to thrive after the pandemic has subsided?

A. As discussed in the Webinar, there are various provisions allowing for technology-based care solutions prior to the Public Health Emergency.

While we do not know to what extent telehealth will be expanded on a permanent basis, we do know that reimbursement for remote patient monitoring and chronic care management were in place before the Public Health Emergency.

Changes in regulatory requirements for these types of technology-based care have encouraged growth and acceptance over the past two years. Medicare's stated goal for reimbursement of remote patient monitoring and chronic care management is improving the health of Medicare patients with chronic medical conditions. As Medicare moves toward Merit-Based Payment system for physicians, reimbursement focuses on maintaining health. The expansion of telehealth during this emergency has shined a light on the benefits of remote technologies.

Now is the time for healthcare organizations to embrace the benefits of technology-based care and the financial benefits not just for the monitoring itself but the evidenced-based improvement in patient outcomes. With remote patient monitoring and chronic care management programs, the providers have access to more than just the condition of the patient on the day of their visit.

Utilizing available technology to virtually manage patients gives physicians access to timely clinical information that allows for better medical decisions based upon continuous and comprehensive data which ultimately allows for more complete medical decision making.

Q. Are there any aspects of COVID-19 Pandemic that we can expect to never return to normal...meaning how might this Pandemic continue to affect us even when it is gone?

A. We can only speculate on those things that may remain in place after the Public Health Emergency. What is known at this time is the 1135 Waiver authority granted to the Secretary of Health and Human Services allowing waiver of statutory provisions is limited by the Public Health Emergency period.

As discussed on the Webinar, the expansion of telehealth is seen by many as long over-due and expands access to healthcare for Medicare beneficiaries. Two key barriers to widespread use of telehealth were acceptance of the technology by both providers and patients. Now that providers have been forced to accept the technology as a viable option for continuing to treat patients during the Public Health Emergency, they are more likely to push for continued reimbursement for these alternatives to patients coming to the office. While some older Medicare beneficiaries are not likely to be as accepting of these virtual visits or the use of technology to replace fac-to-face encounters with their providers, the population aging in to Medicare continues to be a population that has become more accustomed to using computers and the internet.

The statutory limitations on telehealth requiring patients be located at one of eight facility-based locations to

receive telehealth services is likely to be one change to remain in place. This provision was put in place long before technology allowed for secure connections within a patient's home. A permanent change to the geographic limitations on telehealth have been proposed by the telehealth industry for many years.

Waivers that are likely to end with the Public Health Emergency are those related to providing technology-based services to both new and established patients. The need to expand these services to new patients during a public health emergency can be easily justified. However, the need for an existing relationship with a provider before technology-based visits are permitted is not likely to be a first step in the expansion of telehealth coverage by Medicare.

nThrive will continue to monitor regulatory updates both during and after the Public Health Emergency and provide insight into the new "normal" within the healthcare environment.

Q. How are you helping independently owned imaging centers?

A. nThrive can only speak to how the information CMS has released might apply to your practice setting. Under the 1135 Waiver authority, the Secretary of Health and Human Services has expanded the list of services that can be provided via telehealth. To date, radiology services are not included on this expanded list.

One area in which the Waiver authority could impact imaging centers is the provisions related to waiver of cost-sharing (i.e. copays and deductibles) for tests and services related to the assessment for, or diagnosis of, COVID-19 whether or not it results in a COVID-19 diagnosis. Modifier CS, *Cost Sharing Waived,* must be applied to each line item on a claim where that line item is related to the assessment or diagnosis of COVID-19. An example that would apply to imaging centers would be chest x-rays ordered for the purpose of diagnosing pneumonia resulting from COVID-19.

You will find a discussion regarding Modifier CS in the updates published on the portal at: https://www.nthrive.com/_assets/pdf/Coronavirus-nThrive-coding-updates.pdf

nThrive will continue to monitor regulatory updates and publish guidance on our portal for COVID-19 www.nthrive.com/covid19.

Sources

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