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Report on Medicare Compliance Volume 29, Number 25. July 13, 2020
With Telehealth on OIG Work Plan, Beware Pitfalls; CMS Proposes HHA Telehealth Past PHE

By Nina Youngstrom

When a physician's telehealth visit with a Medicare patient on FaceTime cut out after five minutes, they shifted to an audio-only visit, with the physician and patient speaking on the telephone. Although the call lasted for an hour, the physician didn't document the time. That put her in a bind. To bill a time-based evaluation and management (E/M) service, such as a phone call, providers have to document the total time. They can only use medical decision-making to support office visit codes when the audio and visual components are live for the majority of the encounter.

"Defaulting to the telephone-only visits (99441–99443), which were opened up for reimbursement a month into the COVID-19 public health emergency, must be based on time," said Terry Fletcher, a consultant in Laguna Beach, California. "Without time documented, this encounter has no value to bill to a payer."

That's a potential "downfall" of telehealth reimbursement, Fletcher said. Providers also will "tap out" at 21 minutes with the telephone codes, she noted. These are things to keep an eye on, especially now that the HHS Office of Inspector General has added Medicare telehealth services during the COVID-19 pandemic to its Work Plan.[1]

Telehealth continues to be a focal point during the COVID-19 public health emergency (PHE), as providers parse billing nuances, adapt to new developments and worry what the future holds. CMS already embraced permanent changes to telehealth in its proposed 2021 home health prospective payment system regulation,[2] which was published in the June 30 *Federal Register*, and is poised to broaden the telehealth benefit generally beyond the PHE in the 2021 Medicare Physician Fee Schedule, which is due out any minute. There's also momentum in Congress to improve access to telehealth services. Most pending bills address the originating site requirement, which limits Medicare coverage of telehealth to services provided at hospitals and other providers in rural areas, said attorney T.J. Ferrante, with Foley & Lardner in Tampa, Florida. "If I were a gambler, that's what I would bet they would change," he said. Congress suspended the originating site requirement during the PHE, which expires July 25, although Michael Caputo, HHS assistant secretary for public affairs, has tweeted that it would be extended another 90 days. HHS Sec. Alex Azar still has to make it official, and even when that happens, he has the option to revoke the PHE early, without giving providers notice, Ferrante said. The same goes for President Trump and his Jan. 31 declaration of a national emergency, which is supposed to last for one year. "It leads to uncertainty," Ferrante said.

While both the PHE and the national emergency are required to continue with Sec. 1135 waivers, most aspects of telehealth expansion fall outside the Sec. 1135 process, said Chicago attorney Sandra DiVarco, with McDermott Will & Emery. Because most of the telehealth flexibilities, including those related to the originating site, are the result of the Coronavirus Aid, Relief, and Economic Security Act[3] and not the waivers, they will continue even if the national emergency is revoked or expires, she said.

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