



## **Guidance on Billing and Coding for Remote Nephrology Services**

- **Originating Site/Geographic Restrictions on Telehealth Removed**
- **All MCP Visits Allowable by Telehealth (But Still Requiring Audio and Video)**
- **Audio-Only E&M Visits by Telephone Now Covered, Reimbursement Tripled on April 30, Retroactive to March 1**

### **Introduction**

The coronavirus crisis in the U.S. has raised an enormous number of questions relating to billing and coding of remote nephrologist services provided to non-ESRD and dialysis patients. RPA's guidance below on nephrology billing and coding reflect positive revisions made by the Centers for Medicare and Medicaid Services (CMS) for physician services provided by telehealth to Medicare beneficiaries. This guidance focuses on Medicare policies; private payers may move more expeditiously in revising their policies to facilitate remote services provided to kidney patients.

This guidance will be updated as new policies are released and presented in reverse chronological order (most recent first), and subsequent changes to existing policies outlined in previous updates will be noted in bold. Since the initial guidance was disseminated on March 17, the Coronavirus Aid, Relief and Economic Security (CARES) Act was passed by Congress on March 27, CMS released an interim final rule on March 30 that further advances the use of telehealth by nephrologists and other physicians, and now allows reimbursement for telephone interactions that were not previously covered. This was followed up by the release an additional interim final rule on April 30 from which the headline was that the reimbursement for the telephone codes was approximately tripled.

### **April 30, 2020: CMS Issues Further Rulemaking in Response to COVID Pandemic; Reimbursement for Audio-Only Telephone Calls Roughly Tripled**

On April 30, CMS issued the next in a series of interim final rules to further facilitate the delivery of health care in the U.S. during the COVID-19 pandemic, and the biggest news for nephrology and organized medicine broadly was the reevaluation of the telephone codes to approximately triple reimbursement for those services. The less positive news was that RPA's

efforts to convince CMS to allow services on the Medicare approved telehealth list by audio-only telephones were unsuccessful. This means that the status quo requirement that the telehealth services be provided by interactive audio and video remains, and thus **the visits associated with the ESRD MCP outpatient dialysis services cannot be provided by audio-only telephone** and be compliant with current regulation. This and other provisions are addressed below.

### Reevaluation of Telephone Codes

Reimbursement for the recently covered telephone codes (CPT codes 99441-99443) was substantially increased, from a range of about \$14-\$41 to about \$46-\$110. The payments are retroactive to March 1, 2020. CMS based the increase on crosswalks from the relative value units (RVUs) for CPT codes 99212-99214, respectively. This section of the regulation also reiterates the point from previous policymaking that these services can be provided to either new or established patients.

### Addition of Codes to the Medicare Approved Telehealth List

In advance of the release of the rule, RPA and others in the kidney community advocated for a series of codes to be added to the approved telehealth list, including CPT codes 90935 and 90945 for the treatment of acute kidney injury care on an outpatient basis, and CPT codes 90989 and 90993 for home dialysis training (full and incomplete courses, respectively). These requested additions to the approved telehealth list did not happen as part of this interim final rule, but apparently changes of this nature will now happen more quickly. The Agency's fact sheet states "CMS is changing its process during the emergency, and will add new telehealth services on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services." Previously, a full comment and review process was required for additions to the telehealth list; this is no longer the case.

### Telehealth and Audio-Only Services

In the interim final rule, CMS discusses its decision to add some CPT codes to the telehealth list, noting that some of the codes on the list can be provided via audio-only technology; for example, the telephone codes (99441-99443) have been added to the telehealth list. As part of this process the Agency published an [Excel table](#) with all of the telehealth codes listed, and which now includes a column titled "Can Audio-only Interaction Meet the Requirements?", with the word 'Yes' in the column for those services meeting the requirements. Despite RPA's advocacy efforts to allow the care associated with services such as the ESRD MCP to be provided by audio-only means when video technology is not available, the MCP code family is

not among the services that meet these requirements. **Therefore, the MCP visits cannot be provided by audio-only technology.**

### Medicare Shared Savings Programs

CMS also made revisions to Medicare Shared Savings Programs (MSSP) programs in an effort to in essence hold the 517 accountable care organizations harmless due to the impact of the COVID-19 pandemic; these changes are summarized below from the Agency's fact sheet on the rule:

*CMS is making adjustments to the financial methodology to account for COVID-19 costs so that ACOs will be treated equitably regardless of the extent to which their patient populations are affected by the pandemic. CMS is also forgoing the annual application cycle for 2021 and giving ACOs whose participation is set to end this year the option to extend for another year. ACOs that are required to increase their financial risk over the course of their current agreement period in the program will have the option to maintain their current risk level for next year, instead of being advanced automatically to the next risk level.*

The MSSP policy revisions described above do not apply to the ESRD Seamless Care Organizations (ESCOs).

Comments on the interim final rule released April 30 will be due on or around June 30, 2020.

### **March 30, 2020: CMS Issues Rulemaking to Update Telehealth Policies; All MCP Visits Allowable by Audio-Video Telehealth; Covers Audio-Only E&M Telephone Visits**

On March 30, CMS released an urgent and out-of-cycle interim final rule (IFR) that addresses many of the issues surrounding use of telehealth in providing care to Medicare beneficiaries during the COVID-19 public health emergency (PHE). The IFR is the Agency's response to recommendations made by both the kidney community and across organized medicine to facilitate care provided to Medicare beneficiaries in the era of physical distancing and builds on the guidance issued by the Agency on March 17. Key provisions of the IFR are discussed below.

### Nephrology-Specific Issues

Most pertinent for nephrology, the IFR clarifies that all physician and practitioner activities associated with the ESRD MCP outpatient dialysis services can be provided via telehealth. Subsequent to the release of the March 17 guidance, there were differing interpretations as to whether the complete assessments associated with the MCP still needed to be provided face-to-face; the IFR adds all outpatient dialysis services to the list of services that now can be fully

provided via telehealth means. CMS does make a point of stating that just because the codes are on the approved list does not mean they should always be provided via telehealth, noting that:

*“as with other services on the Medicare telehealth list, it may not be clinically appropriate or possible to use telecommunications technology to furnish these particular services to every person or in every circumstance. However, in the context of the PHE for the COVID-19 pandemic with specific regard to the exposure risks noted above, we recognize the clinical benefit of access to medically reasonable and necessary services furnished using telecommunications technology as opposed to the potential lack of access that could occur to mitigate the risk of disease exposure.”*

The rule also includes a section entitled “Required “Hands-on” Visits for ESRD Monthly Capitation Payments” where they cite the 2005 fee schedule rule in which CMS specified that the required clinical examination of the vascular access site must be furnished face-to-face “hands on” (without the use of an interactive telecommunications system) by physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA). For the duration of the PHE, this requirement has been lifted as well, and as with the additions to the telehealth list, this revision applies to all outpatient dialysis services, CPT codes 90951-90970.

It is also worth noting that CMS reiterates in the IFR its definition that “Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.” This means that audio-only telephones are not sufficient for providing services outlined on the approved telehealth service list, including the services in the MCP code family.

#### Place of Service and the New Telehealth Modifier

CMS has developed new guidelines for services provided by telehealth during the PHE. First, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person. **This is a change from the recent previous policy where POS -02 for telehealth was to be used.** Their rationale is:

*This will allow our systems to make appropriate payment for services furnished via Medicare telehealth which, if not for the PHE for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person. Given the potential importance of using telehealth services as means of minimizing exposure risks for patients, practitioners, and the community at large, we believe this interim change will maintain overall relativity under the PFS for*

*similar services and eliminate potential financial deterrents to the clinically appropriate use of telehealth.*

Additionally, CMS is instructing Medicare providers to use a new modifier with telehealth codes during the PHE, -95. **This is another change from recent previous policy, where modifiers were not required for standard telehealth claims.** It is worth underscoring that these changes do not affect reimbursement.

#### Additional Services Now Allowable Via Telehealth

In the IFR, CMS also states that to enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350)

It is also worth noting that for most categories of telehealth services, CMS is removing the requirement that they be provided only to established patients. The Agency's specific language on this point is that "While some of the code descriptors refer to "established patient," during the PHE, we are exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors. Specifically, we will not conduct review to consider whether those services were furnished to established patients."

#### Telephone Codes

In another substantial policy revision affecting all of medicine but with ramifications for nephrology as well, CMS is changing the status indicators for the family of audio-only telephone service codes from an inactive status ('N' for non-covered) to an active status ('A', indicating a covered service). This applies to CPT codes 98966-98968 for qualified non-physician health care professionals (such as nurse practitioners—NPs, and physician assistants—PAs) and for CPT

codes 99441-99443 (for physicians). So, Medicare providers can now be paid for audio-only telephone calls. The RVUs for the two code families are identical, as are the time parameters, all of which are listed below, with the unadjusted national payment amounts based on the 2020 Medicare conversion factor of \$36.09:

CPT codes 98966/99441	(5-10 minutes)	0.40	\$14.43
CPT codes 98967/99442	(11-20 minutes)	0.78	\$28.15
CPT codes 98968/99443	(21-30 minutes)	1.14	\$41.14

### Beneficiary Cost-Sharing Obligations and Patient Consent

The IFR also reiterates the statement made by the HHS Office of Inspector General (OIG) that Medicare physicians and providers will not be subject to administrative sanctions for reducing or waiving a beneficiary’s cost-sharing obligations. The rule specifies that this policy “applies to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.”

Similarly, CMS is easing requirements regarding efforts to obtain patient consent. The CMS fact sheet on the IFR states that “beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.”

### Comments

Although this is an interim final rule, CMS will be accepting comments on the policies outlined in the rule (this is not always the case). Comment on the IFR will be due on or around June 1, 2020. However, it should be noted that there is an expectation among regulatory professionals that additional policy revisions may occur independent of this rulemaking process.

### **March 27, 2020: CARES Act Includes Financial Aid to Physician Practices, Waives Face-to-Face Requirement for Home Dialysis Monthly Services**

On March 27, the [Coronavirus Aid, Relief and Economic Security \(CARES\) Act \(H.R. 748\)](#) passed the House of Representatives by a voice vote after previous passage by the Senate and was signed that day by the President. The \$2 trillion legislation is the largest stimulus package in U. S. history.

Of particular note to nephrology practices, the bill codifies a temporary waiver of the face-to-face visit requirement with home dialysis patients associated with CPT code 90966 (**this change was superseded by the CMS policy changes announced March 30 that allowed all MCP services to be provided via telehealth**). Additionally, the CARES Act allows Medicare

prescription drug plans to provide 90-day refills of covered Part D drugs, including immunosuppressive drugs for post-kidney transplant patients.

The bill also includes language that facilitates the provision of financial relief to physician practices affected by the pandemic. Significantly, the 2% reduction to Medicare fee-for-service claim payments (known as the Medicare sequester) is waived for the period beginning May 1, 2020, through December 31, 2020.

Further, the CARES bill establishes a financial aid program for Medicare providers to which physician practices can apply. CMS' announcement on the program states "Accelerated and advance Medicare payments provide emergency funding and addresses cash flow issues based on historical payments when there is disruption in claims submission and/or claims processing. These expedited payments are typically offered in natural disasters to accelerate cash flow to the impacted health care providers and suppliers. In this situation, CMS is expanding the program for all Medicare providers throughout the country during the public health emergency related to COVID-19. The payments can be requested by hospitals, doctors, durable medical equipment suppliers and other Medicare Part A and Part B providers and suppliers." A [fact sheet](#) on the financial aid program accompanied the announcement.

### **March 17, 2020; Medicare Guidance on Telehealth Released**

On March 17, CMS announced the waiving of originating site and geographic restrictions on the use of telehealth as of March 6, 2020. The announcement states that the policy will be in effect until the public health emergency (PHE) is lifted. Previous guidance on telehealth issued by Medicare dated January 2019 and most of which is still relevant with the exception of the originating site and geographic restrictions, is provided [here](#).

Highlights of what is included in the January 2019 Medicare guidance on telehealth include:

- The list of approved originating sites (which is where the patient is located); physician and practitioner offices and dialysis facilities are listed; significantly, CMS is now allowing the patient's home to be an approved originating site for telehealth services;
- The list of approved distant site practitioners (physicians, NPs, PAs, and CNSs are included);
- The list of approved telehealth services; these include:
  - Outpatient office visits—CPT codes 99201-99215;
  - Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days, CPT code 99231-99233;
  - Individual and group kidney disease education services codes G0420-G0421;
  - All outpatient dialysis services, in-center and home, adult and pediatric, monthly and daily with the exception of the single visit monthly dialysis codes for all ages, CPT codes 90956, 90959, and 90962 (this is a result of CMS

allowing telehealth for visits 2-4 for monthly services several years ago; RPA has advocated for this to be changed previously and will continue to do so);

- Transitional care management services—CPT codes 99495-99496;
- Advance care planning—CPT codes 99497-99498;
- Prolonged service codes—CPT codes 99354-99357;
- Telehealth consultations, critical care—CPT codes G0508-G0509
- Telehealth services claims should be submitted using Place of Service (POS) 02-Telehealth, to indicate the practitioner furnished the billed service as a professional telehealth service from a distant site. **As of March 30, 2020, the POS that would have been used if the service was provided in person should be indicated on the bill, effective March 1, 2020.**
- Modifiers are not required as of January 1, 2018. Use of the telehealth POS code 02 certifies that the service meets the telehealth requirements. **As of March 30, 2020, modifier should be indicated on the bill, effective March 1, 2020.**

#### Other Relevant Issues

- Limitations on Telehealth to Established Patients—CMS' announcement today states that it will not enforce previous requirements that telehealth services only be provided to established patients.
- Billing for Patients in Isolation—For those patients in isolation where a typical physical exam could not be performed, in brief, what can be observed should be reported and what cannot be done should be so stated, and why. Specifically, the physician should:
  - Document that a full-contact physical exam was not possible due to the clinical condition of the patient (not unlike what happens with fresh burn patients, for example);
  - Document any key findings that they can see themselves;
  - Document key physical findings from the physician who has most recently examined the patient and explain why those findings are key for their renal care;
  - Bill at the appropriate level for what the physician "would have done" and document the amount of time spent on the history and physical, recognizing that time may be meaningful if there is an eventual audit.
- CPT codes 99441-443 for Telephone Evaluations—Medicare currently includes these codes in the fee schedule, but they are assigned an 'N' status, denoting a non-covered service. However, with the lifting of the geographic restrictions for normal E&M services, those physician activities that would be captured by the telephonic codes can likely be provided using E&M codes provided a two-way audio and video capabilities are utilized. **As of March 30, 2020, this was changed as noted above, these services are now covered, with an effective date of March 1, 2020.**
- Service code G2010 for Evaluation of Recorded Videos or Images—CMS provides reimbursement for review of recorded videos or images. The services:

- Can be done via asynchronous or synchronous technology;
- Utilizes a patient transmitted photo or video;
- Requires follow-up with the patient within 24 hours;
- Can only be used with established patients, not within 7 days after/1 day prior to an E/M service. **This service can now be provided to new patients, as of March 30, 2020, with an effective date of March 1, 2020.**
- Service code G2012 for ‘Virtual’ Check-Ins—CMS does provide reimbursement for a brief check-in with a patient using service code G2012. The services:
  - Only apply to established patients; **This service can now be provided to new patients, as of March 30, 2020, with an effective date of March 1, 2020.**
  - Must not be related to an office visit that occurred in the previous seven days;
  - Must not result in the patient being seen for a next available office appointment or within 24 hours; and
  - Requires 5 to 10 minutes of medical discussion.
- Nephrologists and Other Physicians in Quarantine—The Medicare telehealth guidance only discuss distant site practitioners, not the site where the practitioners are located, so there are to our knowledge no limitations on quarantined nephrologists providing telehealth or other remote nephrology services from for example their home.
- Allowable Technology—CMS’ announcement restates current policy that allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. Additionally, the March 17 policy revisions allow the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide PHE.

This guidance will be updated as events warrant. Additionally, this information will be posted at [www.renalmd.org](http://www.renalmd.org). Contact [rblaser@renalmd.org](mailto:rblaser@renalmd.org) with any questions about the information in this document.