Telehealth Facility Fee Coding and Billing under CMS COVID-19

March 31, 2020 – Caroline Znaniec, Mid-Atlantic NAHRI Chapter Leader

The COVID-19 pandemic has prompted the Centers for Medicare and Medicaid Services (CMS) to expand upon the use of telehealth services. Expansion efforts have included the waiver of the limitation of geography and allowing the CMS beneficiary to obtain telehealth services outside of a hospital or clinic location. The expansion came as part of the COVID-19 1135 Blanket Waiver. With this expansion, much information has been provided by CMS. However, the information has been delivered in pieces as the situation of the pandemic evolves. Recent publications and communications have prompted the need for clarification more specifically to how an institutional provider may be able to capture, code and bill for telehealth services. This small guide is specifically designed to assist in understanding the requirements for acute care hospitals, skilled nursing facilities, critical access hospitals (under method II), hospital-based ESRD dialysis facilities and hospital provider-based clinics.

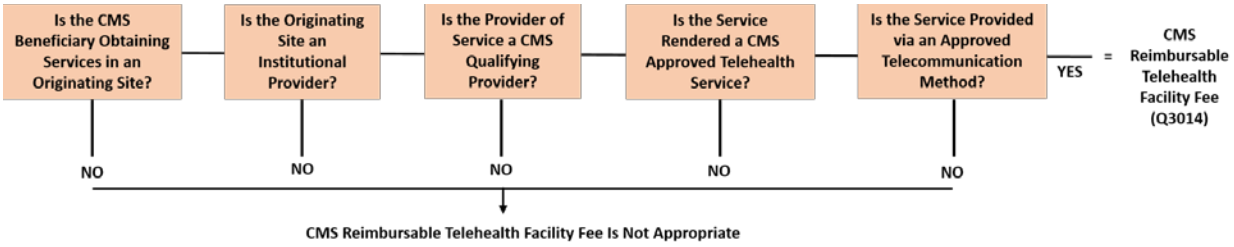
To obtain reimbursement for telehealth services, an institutional provider must meet requirements for originating site, qualifying provider, approved service rendered and approved telecommunication method. The table below provides

Table 1. CMS Telehealth Requirements for Reimbursement Under COVID-19

Institutional Originating Site	*Where the Beneficiary is Physically Located at the Time the Service is Provided*
•Hospital, including provider-based clinics •Critical Access Hospital (CAH), Method II •Hospital-Based Dialysis Facility •Skilled Nursing Facility	
Qualifying Provider	*The Rendering Service Provider, Not Located in the Originating Site*
•Physicians •Nurse practitioners •Physician assistants •Nurse-midwives •Clinical nurse specialists •Certified registered nurse anesthetists •Clinical psychologists and clinical social workers (not DX or E&M) •Registered dietitians or nutrition professionals	
Rendered Service	*The Rendered Service by the Qualifying Provider*
•Included in CMS' Approved Services Listing, including evaluation and management, and consultations	
Telecommunication Method	*The Means of Communication Between the Beneficiary and the Qualifying Provider*
•Two-way real-time interactive communication, audio and visual capability • Includes: Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet, Skype for Business, Updox, Vsee, Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Skype	

Should any one of the requirements not be met, telehealth is not a reimbursable service. *This further assumes that all licensing and credentialing is in place.* A simplified decision tree has been created, to be used together with Table 1, to determine if the facility can capture a facility fee.

Table 2. Decision Tree for Telehealth Facility Fee under COVID-19 1135 Waiver



Once it is determined that a facility fee is appropriate, the institutional provider should submit the facility fee on the appropriate type of bill (TOB), with UB-04 Revenue Code 0780 and HCPCS Q3014. The CPT/HCPCS of the service rendered (e.g. consultation) is not separately reported by the institutional provider, and telehealth modifiers are for distant site reporting only. For institutional originating site providers, the line item date of service should reflect the date of discharge.

Table 3. Summary of Telehealth Facility Fee Billing Requirements

ORIGINATING SITE	CMS INSTITUTIONAL BILLING
Non-Institutional Provider (e.g. Private Doctor's Office)	No Facility Fee is Available
Hospital (including provider-based clinics)	- TOB 12X (Inpatient), TOB 13X (Outpatient) - Billed with HCPCS Q3014, No Modifier, UB04 Revenue Code 780
Critical Access Hospital (CAH), Method II	- TOB 11X (Inpatient), TOB 85X (Outpatient) - Billed with HCPCS Q3014, No Modifier, UB04 Revenue Code 780
Hospital-Based ESRD Dialysis Facility	- TOB 72X - Billed with HCPCS Q3014, No Modifier, UB04 Revenue Code 780
Skilled Nursing Facility	- TOB 22X (Inpatient Covered Stay), TOB 23X (Outpatient Under Arrangement) - Billed with HCPCS Q3014, No Modifier, UB04 Revenue Code 780
Community Mental Health Center	- TOB 76X - Billed with HCPCS Q3014, No Modifier, UB04 Revenue Code 780
Patient's Home	No Facility Fee is Available

The requirements in Table 2 and 3 are specific to CMS' guidance. State and commercial payers may provide for further expansion in any of the requirements. For example, some state departments of health allow for telehealth services to be provided in the absence of video communication, a telephone may qualify as telehealth. Institutional providers should review their state and payer requirements individually.

Institutional providers may also consider opportunities to capture, code and bill non-face-to-face services that may also be appropriate during the pandemic. This can include e-visits and transitional care management.

Valuable links to this topic include those below:

COVID-19 1135 Blanket Waiver
https://www.cms.gov/files/document/se20011.pdf

CMS Telehealth FAQs – March 17, 2020
https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

CMS Approved Telehealth Services
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

CMS Guidance on HIPAA Approved Telecommunication Methods
https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

CMS Claims Processing Manuals
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912

Contact

Caroline Znaniec is a Managing Director in Strategy, Technology, and Transformation, Healthcare Advisory. She is also a Mid-Atlantic Regional Chapter Leader. This guide has been prepared for information purposes and general guidance only and does not constitute legal or professional advice. You should not act upon the information contained in this publication without obtaining specific professional advice.

caroline.znaniec@cohnreznick.com