

# CORONAVIRUS DISEASE 2019 (COVID-19)

## Facility Guidance for Remote Services Based on CMS Interim Final Rule published April 30, 2020



**Audience:** Revenue Integrity, Patient Financial Services, MGPS, HIM, Integrity & Compliance Officers, Care Management/Utilization Review

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**COVID-19 Response Team Owner:** Finance

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What's Changed: Guidance for remote services relocated to a patient's home that are normally performed in an on-campus provider-based location of the hospital.

On April 30, 2020 CMS published an Interim Final Rule which provided guidance on facility billing of remotely furnished services and facility component of physician/provider services furnished via Telehealth. That Rule was summarized and can be found here: [COVID Interim Final Rule-2 Released 043020](#)

CMS is holding Office Hours calls twice weekly and they have provided information during these calls that is not included in the written Rule. Some of this information conflicts with the Rule and may cause confusion. In order to provide more clarity to the RHMs on billing of the facility services, System Office Legal, Integrity & Audit Services, and Revenue Excellence have created this document. It is structured into three areas:

- Facility component of a Telehealth visit furnished by a physician/provider
- Relocation to a Physical Location (not the patient's home)
- Hospital Billing of Remote Services Provided to Patients at Home (expanded PBC location)

On July 28, 2020 CMS updated their COVID-19 FAQ for Medicare Fee-for-Service Billing document ([Frequently Asked Questions to Assist Medicare Providers \(PDF\)](#)). CMS has updated this FAQ to include information published in the Interim Final Rule and information they have provided during their Office Hours calls. Most recently, CMS added section LL. Billing for Hospital Remote Services. This COVID-19 Communication document has been updated to include any new or clarified information.

**All of the information applies to patients who are registered as hospital outpatients and would normally have presented to the hospital department/clinic for the visit.** This information is applicable to Medicare and Medicaid programs that closely follow Medicare.

### **Facility Component of Telehealth Visit Furnished by a Physician/Provider from a PBC**

CMS has added clarification on this section based on whether the physician/provider is a "distant site" provider. CMS considers "distant site" to mean the physician/provider is not located in the hospital or a provider-based location when providing the services.

Based on the updated CMS guidance, it is imperative that the record documentation include where the patient is located and where the physician is located when providing Telehealth visits.

- When a "distant site" physician/provider, that normally practices in a provider-based clinic, provides a Telehealth visit to a patient in their home, the facility can bill Q3014 during this PHE (instead of the usual facility E&M).
  - The facility component is to be billed with Q3014, which is not technically paid under OPPTS.
  - For each time it would be appropriate to bill Q3014 under the PHE, bill always with -PN no matter whether the normal location is on-campus, excepted off-campus, or non-excepted off-campus
    - Includes E&M codes, telephone only codes, and other codes on Telehealth list. The link includes the current Telehealth list: <http://www.trinity-health.org/workfiles/covid-19/covered-telehealth-services-for-phe-for-the-covid-19-pandemic.xlsx>
  - Use DR condition code
  - Apply modifier CS if appropriate
  - Start with March claims first and see if MAC accepts and no denials
  - The CMS Regional Office (RO) request is not needed for these services provided in the patient's home because we are billing with PN. Payment will not be impacted since this code is not paid under the OPPTS mechanism.
- When a physician/provider, that normally practices in a provider-based clinic, provides a Telehealth visit to a patient in their home, and the physician/provider is located in the hospital or in a provider-based clinic while providing the service, the facility can bill G0463 as if the service occurred in person since the patient's home is being treated as an off-campus department of the hospital during the PHE.
  - The facility component is to be billed with G0463.
  - For services that would normally be done in an off-campus provider-based clinic, we are providing two options so sites can determine which works best for their EMRs and billing systems.
    - Option 1: Bill with the PO or PN modifier that would normally be used if that visit was in-person at the off-campus location. (For most of our hospital billing systems, PO or PN is automated based on the location.)
      - The CMS Regional Office (RO) request **is needed** for the locations that bill with PO modifier.
    - Option 2: Apply PN modifier to these visits, even if the location usually bills with PO modifier.
      - The CMS Regional Office (RO) request **is not needed** because these services are billed with PN modifier (the payment is reduced whether HCPCS code G0463 is billed with PO or PN modifier).
  - ~~For services that would normally be done on-campus, bill without either PO or PN modifier to retain the full OPPTS payment. (Because G0463 with PO modifier has reduced payment for off-campus locations, CMS may inadvertently reduce payment for the normally on-campus services if PO modifier is used.)~~
  - For services that would normally be done on-campus, that have relocated to a patient's home, bill with the PO modifier. The previously located on-campus department is now considered an off-campus location at the patient's home, therefore the PO modifier is required.
    - The CMS Regional Office (RO) request **is needed** for these services provided in the patient's home.
  - Use DR condition code
  - Apply modifier CS if appropriate

#### **Relocation to a Physical Location (not the patient's home)**

- For a normally on-campus or excepted off-campus location which temporarily relocates to a physical location
  - Bill with coding for actual services provided by hospital staff
    - For example, if the location is a clinic, the facility portion would bill the E&M as normal (G0463)
    - For example, if the location provides PT, bill using the regular PT CPT codes

- Bill with PO modifier
- Use condition code DR
- Modifier CS may be needed if criteria are met
- The CMS RO request must be completed within 120 days of starting services in the temporary location.
  - Refer to Q&A 3 in **section G. Hospital Outpatient – Locations off of Hospital Campus** of the CMS FAQ document for details on the data elements. CMS notes the files should be encrypted.
  - When this Communication document was published in mid-May it recommended to begin these CMS RO requests. If they have not been submitted, make sure to complete this within 120 days of when services began at the temporary location. For services that may have relocated in March, the 120-day deadline is fast approaching.
- For a non-excepted off-campus PBD which temporarily relocates to a physical location
  - Bill with coding for actual services provided by hospital staff.
    - For example, if the location is a clinic, the facility portion would bill the E&M as normal (G0463)
    - For example, if the location provides PT, bill using the regular PT CPT codes
  - Bill with PN modifier
  - Use condition code DR
  - Modifier CS may be needed if criteria are met
  - Do not need to submit the CMS RO request since the normal location is non-excepted.

#### **Hospital Billing of Remote Services Provided to Patients at Home (expanded PBC location)**

- For services that are not paid under OPSS (e.g., PT, OT, ST, DSMT, MNT) normally provided in an on-campus or excepted off-campus location that are being provided by hospital staff to patients remotely in their homes
  - Bill with the normal CPT codes/charges for the services provided
  - Anything not paid under OPSS, bill with PN modifier
  - Bill with condition code DR
  - Do not need to submit the CMS RO request since the services are not paid under the OPSS mechanism
  - NOTE: CMS mentions that services that are paid under Part B and on the Medicare Telehealth list can be billed with modifier 95 even when provided by hospital staff remotely. However, this is limited to only services on the Medicare Telehealth list. System Office does not recommend using modifier 95 but rather using the PN modifier and condition code DR as noted above.
- For services that are paid under OPSS (e.g., behavioral health) normally provided in an on-campus or excepted off-campus location that are being provided by hospital staff to patients remotely in their homes
  - Bill with the normal CPT codes/charges for the services provided
  - Services would then be billed PO modifier
  - Bill with condition code DR
  - RO request would need to be completed for services paid under OPSS in order to maintain full payment amount. Will need to submit a request to the CMS RO within 120 days of starting to provide the services.
    - May 19, 2020 Communication:
      - CMS guidance is evolving regarding what information needs to be included with the request and that CMS indicated they were developing further clarification.
      - Sites can submit the RO request now and send any additional information CMS identifies later, or, they can wait until closer to the 120 days in hopes that CMS will have provided clarification by then.
    - June 30, 2020 Communication Update:
      - CMS has provided information in the June 19, 2020 FAQ document. Refer to Q&As 8 – 11 in **section G. Hospital Outpatient – Locations off of Hospital Campus** for details. CMS notes the files should be encrypted.
      - If the CMS RO request has not been submitted, make sure to complete this within 120 days of when services began in the patient's home for each location/department. For services that started in March, the 120-day deadline is fast approaching.

The COVID-19 Revenue Excellence subcommittee recommends that each RHM's COVID-19 Committee coordinate the CMS Regional Office requests. System Office Legal created this template to assist with the CMS RO Requests.



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