

Radiation Oncology Providers, March 2020

Provided for Elekta Customers

CMS Expands Telehealth Services in Response to COVID-19 Guidelines

In response to the ongoing life changing events due to COVID-19 and the need for social distancing, CMS released some adjustments to expand the telehealth guidelines on March 17, 2020. To reduce the amount of personal contact with patients and caregivers, for services such as new and established patient visits, these visits can now be performed by telehealth and cover services as far back as March 6, 2020. This means patients do not have to be at an originating site where the primary services were provided, typically in a rural or hard to staff location. Instead, patients can be in their home and conduct the telehealth visit with video capabilities, such as FaceTime, Skype, Zoom and other similar video conferencing systems.

CMS also indicated they would not enforce that telehealth services could only be provided to established patients. Meaning audits would not focus on or review whether there was at least 3 years since the patient was seen by the physician or physician group.

In the oncology settings the expansion of the telehealth services applies to new patient and follow-up visits. This will allow for patients to be in their homes or where they may be quarantined, and the billing practitioner can conduct a visit by video. The codes available to be billed include 99201-99215. The modifiers typically used for telehealth billing are not to be applied in these circumstances. CMS has indicated that for these scenarios the only change to the billing is the reporting of place of service (POS) 02 for telehealth. Reimbursement will be in line with the MPFS values for the codes.

If video conferencing is not supported for a visit with the patient, there are a few phone call E/M coding options. For a brief check-in by telephone, CMS offers code 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*) for an established patient visit. One stipulation of code G2012 is the patient must give consent to be billed for the check-in. The billing practitioner is the only one who can perform this check-in and must document the consent, what took place as part of the call and the time spent.

Additional codes include 99441-99443, these codes currently have rates assigned but include the status of “N” under MPFS which means “*Non-covered services: These services are not covered by Medicare.*” The codes for E/M by telephone may be accepted by commercial payers. Documentation for these services would still need to support what took place as part of the phone call and the time spent. In addition, the guidelines by the AMA indicate these codes are initiated by the established patient, so the note in the medical record would need to support this as well.

For reference the telephone E/M codes are defined as follows:

99441 – Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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

99442 – Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 11-20 minutes of medical discussion

99443 – Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian 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; 21-30 minutes of medical discussion

The expansion of the telehealth services and use of the telephone E/M codes does not replace the work requirements for services such as radiation oncology physician management visits. The expansion of the telehealth services did not add codes to the list available, it only opened some of the criteria for the codes on the list as finalized in the 2020 final rules. On that list of codes are the new and established patient visits 99201-99215.

Physician management services, CPT® 77427-77469, are not on the telehealth list of services and were not included in the telehealth expansion transmittals released by CMS. The patients are already present for treatment in the radiation therapy department, seeing the patient to bill for a management visit requires the physician to perform at least one exam of the patient in person. The physician management visits have not changed and neither have any of the other radiation oncology services.

The expansion of telehealth services to allow for the patient to be at home and use of video conferencing by telephone or other means only applies to the telehealth codes on the list as approved and released at time of 2020 final rule. According to Seema Verma, administrator of the Centers for Medicare and Medicaid Services, the expansion of the telehealth guidelines was meant to protect vulnerable seniors by allowing them to not have to physically visit the hospital and or physician office. The changes were not meant to allow for physicians to not be present on-site for services. If physicians are billing for services at this time, they are expected to be present and personally providing the work as valued by the RVUs of the given codes billed.

There is no exact end date as of now for the expanded waiver for telehealth services. CMS indicated the following, "...effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home." Once the Public Health Emergency has been canceled, it is expected a return to the previous telehealth standards will be enacted.

CMS has a factsheet and FAQs document which has additional information which may be helpful.

- <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>
- <https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf>