POWERS

POWERS PYLES SUTTER & VERVILLE PC

ATTORNEYS AT LAW

MEMORANDUM

This memorandum is solely for educational purposes and the matters presented herein do not constitute legal advice with respect to your particular situation

TO: Powers Clients and Friends

FROM: Mark Fitzgerald and Natalie Dobek

DATE: July 22, 2020

SUBJECT: Latest Turn in Hospital Billing of Clinic Visit Code G0463 in Connection with Telehealth Visits During COVID-19

On Tuesday, July 21, in a CMS "Office Hours" COVID-19 call, CMS provided the latest guidance on billing HCPCS code G0463 when a physician is providing a telehealth service to a patient in the patient's home, which has been designated as a provider-based department. The guidance represents a departure from previous oral advice provided by CMS and is the latest twist in a confusing mix of written guidance and oral advice on the subject of how hospitals should bill for these visits.

The uncertainty surrounding billing for clinic visits facilitated using telehealth has created significant administrative burdens for hospitals and threatens a dramatic reduction in reimbursement for these visits, as compared to pre-pandemic time periods. Last night, CMS acknowledged the need to provide "super clear" written guidance on this topic, and promised to do so very quickly. But until that guidance is published, hospitals should be cautious about billing a G0463 code with a telehealth visit.

HOPD Billing and HCPCS Code G0463

Since CMS published its first Interim Final Rule in response to the COVID-19 public health emergency (PHE) on March 31, physicians have been permitted to bill for telehealth visits as if they were office visits. This change was an important step to eliminate economic disincentives to curbing the spread of the novel coronavirus, by preserving the status quo for physician office reimbursement. At that time, however, CMS did not take similar steps to protect payments to hospital outpatient departments and provider-based clinics (HOPDs) for patient visits conducted via telehealth.

1501 M STREET, NW ■ SEVENTH FLOOR ■ WASHINGTON DC 20005 ■ PH 202.466.6550 ■ www.PowersLaw.com

Ordinarily, when a patient is seen at a HOPD clinic, the hospital bills Medicare for a clinic visit using HCPCS code G0463. This fee covers the hospital's administrative expenses associated with the visit. The reimbursement for that code varies by hospital but the adjusted payment rate is approximately $115 for an on-campus department, and $46 for an off-campus department. The physician—often an employee of the hospital for whom the hospital bills on an assignment basis—bills the appropriate evaluation and management (E&M) code for the professional service. The reimbursement for the E&M code is reduced from the comparable office visit payment (by approximately 60%) to account for the site of service, but the combined reimbursement overall is greater than what would be paid by Medicare for the same service rendered at a physician's office. This discrepancy has long been a target of CMS, which has been trying for years to achieve "site neutrality" between payments to HOPDs and office-based practices.

CMS' site neutrality policy ignores that there are substantial additional costs to operating a provider-based facility, ranging from lower productivity of physicians to higher costs of labor at hospital salary rates. In addition, the policy has been the subject of ongoing litigation, which is beyond the scope of this memorandum. For purposes of this topic, we wish to emphasize that the authorities for permitting expanded use of telehealth during the pandemic were intended to remove obstacles to treating patients at their homes to reduce the risk of infection. The site neutrality policy is not relevant to this goal.

The April 30 Interim Final Rule and HOPD Billing for Telehealth Visits

Following the initial release of the expanded telehealth guidelines on March 31, callers to CMS' weekly "Office Hours" sessions on COVID-19 asked whether a provider-based clinic could continue to bill a HCPCS code G0463 for a telehealth visit. Callers pointed out that there also was no mechanism for a hospital to bill a telehealth "originating site" facility fee for a telehealth service performed by a physician from a hospital outpatient department or other "excepted" provider-based clinic. This absence of guidance on hospital clinic visit billing left hospitals with a strong economic incentive not to use telehealth for their clinic visits, as it appeared there would be no payment for them. In at least one instance, CMS apologized for the confusion, and on several occasions, CMS promised additional guidance.

In an Interim Final Rule published on April 30, CMS permitted hospitals to bill an originating site fee for telehealth services subject to certain requirements (see our memorandum of May 12), but made no mention of whether a hospital could also bill a G0463 code for these visits. CMS' apparent unstated choice to allow hospitals to bill an originating site fee but not a clinic visit fee has significant financial consequences. Ordinarily (pre-pandemic), a hospital would have seen the patient at its clinic and would have billed code G0463 for its hospital facility fee. The reimbursement the hospital would have received for that code (approximately $115 for an on-campus department, and $46 for an off-campus department) is substantially more than the originating site fee (HCPCS code Q3014) that hospitals are now permitted to bill, which has a payment rate of only $26.65. While the substitution of an originating site fee for a clinic visit

fee brought the total reimbursement for HOPD clinic visits closer to site neutrality, which may have been CMS' unstated goal, it is achieved at the expense of discouraging the use of telehealth as a strategy to curb infection risk.

The Case for Permitting Clinic Visit Billing (G04630)

CMS' explanation for permitting hospitals to bill an originating site fee was that its "blanket waivers" for the PHE include a waiver of all of the requirements of the regulation governing provider-based status (42 CFR § 413.65), as well as the Medicare conditions of participation for hospitals governing physical facility requirements (42 CFR §§ 482.41 [PPS hospitals] and 485.623 [critical access hospitals]). These waivers are meant to facilitate the availability of temporary expansion sites. Consequently, a hospital may designate a patient's home as a temporary provider-based facility and begin billing the originating site fee. The patient must be registered as a hospital outpatient and the patient will be considered present in the hospital's facility when the telehealth service is performed for billing purposes.

In theory, if a patient's home is considered to be part of the HOPD then a hospital should be able to bill a clinic visit (HCPCS code G0463) in connection with a physician E&M service provided via telehealth because both the patient and the physician are in the same HOPD location. Indeed, both the originating site fee and the clinic visit code arguably should be billable. The originating site fee, HCPCS code Q3014, is a separate charge that is intended to pay for the room and telecommunications technology equipment. It does not substitute for reimbursement of the hospital's administrative costs associated with performing a clinic visit. Hospitals continue to incur these administrative costs whether the patient is being treated in a remote provider-based location (the patient's home) or at the hospital. More importantly, permitting clinic visit billing for patients seen through telecommunications technology would achieve CMS' primary objective of promoting infection control by eliminating an economic disincentive to the use of telehealth to help prevent the spread of the novel coronavirus.

The Latest Guidance on Billing HCPCS Code G0463

Since the issuance of the April 30 interim final rule, CMS has vacillated between permitting and prohibiting clinic visit billing for HOPD visits performed via telehealth. We were advised by CMS via email in late May that a hospital may only bill the originating site fee for these visits and CMS appeared to have confirmed this advice in an Office Hours discussion immediately thereafter. But subsequently, in a CMS "Office Hours" call on June 16, CMS reversed course, stating: "*if both the patient and the physician are in the hospital, either in the hospital proper or through the temporary site extension, then they would bill for the clinic visit using the G code you described.*"[1]

[1] CMS "Office Hours" COVID-19 (June 16,2020) (Unofficial transcription taken from the call's close captioning feature).

Last night, in another CMS "Office Hours" call, CMS reversed course once again when asked about billing the G0463 code versus the Q3014 code. Multiple hospitals expressed their confusion surrounding the use of the G0463 code versus the Q3014 code when the physician is providing a telehealth service to a patient in their home, which has been registered as a provider-based department. One stakeholder presented a scenario in which a hospital outpatient department physician practice is now rendering services remotely to a patient's home as an extension of a hospital outpatient department. Pre-COVID, the hospital billed the G0463 code as the hospital's fee associated with the physician's service if the patient was in the clinic. The stakeholder asked for confirmation that it could continue billing the G0463 code. CMS reversed course once again, stating that the G0463 code would not be appropriate in that scenario: "*rather than reporting the G code for the clinic visit in that case, because it's Medicare telehealth service, the appropriate code for the facility to bill would be that originating site facility fee*."[2] This answer was met with frustration as some hospitals had already changed their billing mechanisms to bill the G0463 based on previous oral advice. CMS promised to provide additional written guidance on this issue.

Based on this latest oral advice from CMS, hospitals should be cautious about billing a G0463 code with a telehealth visit until CMS provides further written clarification of its position. In the Interim Final Rule, CMS described the originating site fee as the "statutory payment that is made to the facility for providing the site where the patient is located." If CMS had intended to allow for G0463 billing for these visits we would have expected it to state so in the rule. Ultimately, CMS may justify not permitting hospitals to bill a G0463 clinic visit for a physician E&M service rendered via telehealth, even though it permits hospitals to bill for other types of hospital clinical staff services facilitated through telehealth (such as therapy, education and training, which is expressly permitted in the Interim Final Rule), on the basis that the former requires a face-to-face encounter while the latter does not.

CMS has promised to provide additional written guidance on this topic quickly that will be "super clear." Hospitals should monitor this issue closely for continuing developments.

***

This memorandum is solely for educational purposes and the matters discussed herein do not constitute legal advice with respect to your particular situation.

For further questions regarding this or other COVID-19 matters, please contact Mark Fitzgerald at Mark.fitzgerald@powerslaw.com or Natalie Dobek at Natalie.dobek@powerslaw.com or the Powers professional with whom you normally work.

For the latest news, information, and insights on COVID-19, please visit our resource hub at https://www.powerslaw.com/covid-19/.

[2] CMS "Office Hours" COVID-19 (July 21,2020) (Unofficial transcription taken from the call's close captioning feature).