Telehealth and DSMT: Answers to Commonly Asked Questions

ADCES has held a series of webinars Q&A over the past several weeks. Here is that conversation. *Please note: Information is current as of May 6, 2020. This document will be updated as new rules are released. The information provided by this FAQ is intended as guidance only and is not intended as legal advice. Please contact each payor to determine the specific coverage and reimbursement practices and policies.*

Q1: Who can provide DSMT via telehealth?

The following types of providers may facilitate and get payment for covered telehealth services (subject to State law) are:

- Physicians.
- Nurse practitioners (NPs).
- Physician assistants (PAs).
- Nurse-midwives.
- Clinical nurse specialists (CNSs).
- Registered dietitians or nutrition professional.
- Providers at FQHC's and RHC's (please see Q19 for more details related to CARES Act).
- See Q2 for additional information regarding RNs, pharmacists and other DSMT providers.

Q2: Can RNs and Pharmacists furnish DSMT via telehealth?

Hospital Outpatient Settings: Yes- CMS has issued guidance (see Q10 and Q11) that DSMT providers, including RNs and pharmacists, can provide DSMT services to Medicare beneficiaries when the beneficiary is in their home or other location. This change is effective March 1, 2020 (retroactive) and lasts through the duration of the COVID-19 PHE.

FQHCs/RHCs: Yes, one-on-one DSMT visits can be billed (using G0108) for telehealth during the PHE. Telehealth services can be provided by any healthcare practitioner working for the RHC or the FQHC within their scope of practice. See Q19 for more information.

Other settings, including provider practices, clinics, pharmacies, etc: We are seeking additional clarification from CMS on this, though we believe the intent is there. CMS issued a blanket waiver

waiving restrictions around which providers are eligible to provide services via telehealth. Now, any healthcare professionals eligible to bill Medicare for their professional services can furnish distant site telehealth. We recognize that DSMT is a unique benefit as many different types of providers can furnish DSMT under the accredited/recognized program as the billing entity. We will alert our members as soon as CMS issues additional guidance.

Q3: Are both audio and video required for CMS telehealth and what is the definition?

When providing DSMT via telehealth, providers should use technology with audio and video capabilities to ensure two-way, real time, interactive communication. On April 30, CMS updated their guidance to say that only in cases when audio and video are not possible, CMS will allow DSMT to be furnished with audio only. This change is indicated on the list of Medicare telehealth services and in a separate document addressing hospital outpatient services.

If providing DSMT audio only, ADCES recommends that providers document the mode of delivery, the reason the service is being provided audio only and any other relevant information. DSMT provided via an audio-only format follows the same billing/modifier rules as DSMT furnished via telehealth using two-way audio and video communication (see Q6). These rules apply to both new and established patients and extend through the duration of the COVID-19 public health emergency (PHE).

Q4: Can I provide DSMT by phone? Can I provide any other services by phone?

See Q3. As of April 30, CMS has designated DSMT as one of a limited number of services that can be furnished with audio only. CMS is clear that DSMT can be furnished exclusively with audio only in cases when audio and video are not possible.

CMS has identified other codes that can be used by other qualified healthcare professionals such as social workers, speech language pathologists, and physical and occupational therapists. This list does not include RNs or pharmacists. As per the guidance from the Academy of Nutrition and Dietetics (AND), RDNs may temporarily utilize these codes. Physicians, nurse practitioners, and physician assistants should use CPT® codes 99441—99443. **These should not be used for DSMT.**

- **CPT code 98966:** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- **CPT code 98967:** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent or guardian not originating from a related assessment and management service provided within the previous 7

days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.

- **CPT code 98968:** Telephone assessment and management service provided by a qualified nonphysician healthcare professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion.

Q5: Can G2061, G2062, G2063 codes be used for phone visits by RN's or other clinicians?

These codes are designated for e-visits, specifically online assessment and management of a patient. These are not specifically designated for phone visits. The Medicare fact sheet states that RDNs, physical therapists, occupational therapists, speech language pathologists and clinical psychologists can provide the following e-visits and bill the following codes (RNs and pharmacists are not listed).

- **G2061**: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes.
- **G2062**: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes.
- **G2063**: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

While these code descriptors specifically say "established patient" CMS has stated they will relax enforcement of this aspect of the code descriptor**.**

The RDN reference is available here.

Q6: How does a qualified provider bill for telehealth services?

NPs, PAs, CSWs and RDNs can furnish and bill for DSMT via telehealth if they are instructors in either an accredited or recognized program. Medicare telehealth services are generally billed as if the service had been furnished in-person. DSMT would still be billed under the accredited or recognized program entity using G0108 for 1:1 and G0109 for group. Prior to March 30, 2020, CMS advised the use of the Place of Service (POS) 02 modifier. As of March 30, CMS is now asking providers to report the POS code that would have been reported had the services been provided in person. For example, you may use the POS 11 modifier to indicate a service that would have been provided in an office. CMS has also directed providers to report the 95 modifier for services reported via telehealth. You should now use the appropriate POS modifier and the 95 modifier. The POS code 02 code is not incorrect, CMS has just added more specific guidance. ** **FQHC's and RHC's: Please see Q19 for details. Hospital Outpatient Programs billing on UB04 form, please see Q10-11.****

POS codes: https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set

Q7: How will I report DSMES furnished by phone or telehealth during the pandemic on my annual status report for accreditation?

Please include all individuals who have received DSMES through your accredited program. The Annual Status Report (ASR) does not differentiate between types of visits at this time and, regardless of your ability to bill for these services, those participants can and should be included in your ASR data.

Q8: Can we use code G2012 for phone calls?

CMS has broadened the use of G2012. These codes describe a brief communication between the provider and patient using a variety of communication technology modalities including discussion over the telephone or exchange of information through video or image. These services are meant to represent a brief communication for the sole purpose of determining if another visit is required. CMS has noted that during the PHE for the COVID-19 pandemic, practitioners such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech-language pathologists might also utilize virtual check-ins and remote evaluations. Providers who can bill for evaluation and management (E/M) services can also use these codes. RDNs, RNs and pharmacists are not included on this list.

- **G2012**: Brief communication technology-based service, e.g. virtual check-in by a physician or other qualified healthcare 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.

Medical necessity must be met to bill G2012. This code was originally intended to evaluate if an office visit was needed. Some examples for this code may be patients that had an office visit that was cancelled or patients with medical concerns.

Q9: Are group classes still required for Medicare beneficiaries during COVID-19?

Referring providers can request 1:1 in the referral order and indicate "Covid-19 risk" as the special need. They may also request 1:1 in cases where no group classes are available for 2 months due to Covid-19 social distancing measures. For existing referrals requesting group visits, MNT and DSMT providers should document that the visit was provided via telehealth due to "no group classes available for 2 months due to Covid-19" rather than adding another burden on the referring provider to write another referral. Group DSMT and MNT codes are also available for telehealth if programs have the training, software, and capacity to facilitate and individualize DSMT virtually. DSMES assessment is still required. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

Q10: How do DSMT programs in hospital outpatient settings that submit claims via the UB-04 bill for telehealth? Can RNs and pharmacists provide the service?

On April 30, CMS provided updated guidance on how hospitals should bill during the COVID-19 pandemic. When services like DSMT are furnished by hospital clinical staff, including RDNs, RNs and pharmacists, the hospital should bill for these services as if they were furnished in the hospital and consistent with any specific requirements for billing Medicare during the COVID-19 PHE. This means billing DSMT as you normally would on the UB-04 form (if that's how you usually submit claims).
In order to provide DSMT services remotely, CMS will allow the hospital to consider the beneficiary's home and any other temporary expansion location operated by the hospital during the COVID-19 PHE to be a provider based department of the hospital, so long as the hospital can ensure the locations meet all of the conditions of participation, to the extent not waived. The beneficiary must also be registered as an outpatient of the hospital. These changes are effective as of March 1 and extend through the duration of the PHE.

Summary:

- DSMT services can be provided in the hospital outpatient setting remotely to a patient in the patient's home.
- DSMT services can be provided by any DSMT provider, including RNs and pharmacists, in the hospital outpatient setting in accordance with scope of practice.
- The patient must be a registered outpatient of a hospital
- The patient home must be made provider-based to the hospital.*
- All DSMT requirements must be followed.
- If you previously billed using the UB-04, you will continue to bill the same way.
- DSMT can be furnished via audio, only if audio and video are not possible.

*We are seeking additional guidance here, but ADCES recommends you work with your billing and compliance departments to determine the appropriate process.

Sources:
Please refer to page 46 of the April 30 interim final rule with comment
Please refer to pages 1-4 of the Hospitals: CMS Flexibilities to Fight COVID-19 Fact Sheet

Q11: We only bill through the hospital, we do not bill through individual NPI numbers. Can we still bill in this way for telehealth?

See Q10. The hospital would still bill for DSMT under the hospital NPI. The difference now is that if the service is provided (remotely) to the patient in the patient's home, the patient's home must be made a provider-based department of the hospital. CMS is essentially saying that they don't have a mechanism to bill telehealth for those in the outpatient setting (UB-04) so they are allowing the hospital to consider the patient's home part of the hospital. This is part of CMS' Hospitals Without Walls initiative.

Q12: When the pandemic ends, will CMS discontinue this ability to bill for telehealth?

CMS has been clear that the telehealth and other policy changes implemented to address the COVID-19 pandemic are only for the duration of the public health emergency (PHE). The guidelines around providing DSMT via telehealth that were established before the COVID-19 pandemic will remain.

Q13: I provide DSMES in a private physician's office; can I provide telehealth from my home?

CMS is allowing providers to furnish telehealth services from their home without reporting their home address on their Medicare enrollment. This means that you can continue to bill from your currently enrolled location.

Q14: How much does Medicare pay for telehealth services?

Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

Q15: Will CMS enforce an established relationship requirement?

CMS has clearly stated that clinicians can provide telehealth services to new or established patients. They have stressed that it imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness.
https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

Q16: What platforms are acceptable for Telehealth (FaceTime, etc)?

Please note this may not be a comprehensive list, but a good starting point.

Telehealth platforms with HIPAA and BAA readiness for providers

- Skype for Business / Microsoft Teams.
- Updox.
- VSee.
- Zoom for Healthcare.
- Doxy.me.
- Google G Suite Hangouts Meet.
- Cisco Webex Meetings / Webex Teams.
- Amazon Chime.
- GoToMeeting.

Acceptable: non-public facing communication

- Products that allow only the intended parties to participate in communication.
- Some will be suited for individual, some allow for many participants.

- Apple FaceTime, Facebook Messenger video chat, Google hangouts video, Whatsapp video chat, Skype, Zoom.
- Some products would also allow texting applications with end-to-end encryption.

Free telehealth Platforms by EHR vendors

- AdvancedMD is offering certain features within its patient engagement suite free of cost until the end of May.
- Prognocis will be giving its complete telehealth platform free of cost to all its customers.
- Chartlogic has just launched its telehealth service and will be offering it for free to all its customers.
- Drchorno Two of its telehealth partners have special 90-day free trial offers for all Drchorno customers.
- eclinicalworks is providing accelerated activation, training, and setup of telemedicine services for all practices; non-customers can also purchase their stand-alone telehealth platform.

Additional Resources

https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf

https://www.hhs.gov/hipaa/for-professionals/special-topics/hipaa-covid19/index.html#

Q17: Do I need to be an ADCES-accredited or ADA-recognized program to bill Medicare for G0108 and G0109?

Yes.

Q18: Would this telehealth delivery be considered a curriculum change for accreditation?

No, most likely you can use the same curriculum, but your delivery methods will change. ADCES does not need to be notified, but you may want to track how and what you did to keep in your binder for your own future reference.

Q19: Can diabetes care and education specialists provide DSMT via telehealth in a federally qualified health center (FQHC) or rural health center (RHC)?

Yes! The CARES Act passed by Congress in late March authorizes FQHCs and RHCs to provide services via telehealth during the COVID-19 public health emergency (PHE). On April 17, CMS issued specific telehealth billing and programmatic guidance for FQHCs and RHCs.

Under normal circumstances, accredited/recognized DSMT programs in FQHCs are reimbursed for one-on-one DSMT visits using code G0108. This service is now able to be provided via telehealth during the PHE. CMS defines telehealth as real-time audio-video communication (see previous questions for more detailed definition). Here are some additional details:

- Services can be provided by any healthcare practitioner working for the RHC or the FQHC within their scope of practice.
- Practitioners can furnish telehealth services from any location, including their home, during the time that they are working for the RHC or FQHC, and can furnish any telehealth service that is approved as a distant site telehealth service under the Physician Fee Schedule (PFS). (G0108, is on the PFS).
- For telehealth services furnished between January 27, 2020 and June 30, 2020, RHCs and FQHCs must add modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim.
- For telehealth services furnished between July 1, 2020 and the end of the COVID-19, PHE, RHCs and FQHCs will use an RHC/FQHC specific G code (G2025) to identify services that were furnished via telehealth; RHC and FQHC claims with the new G code will be paid at the $92 rate.

Please reference the guidance document for billing information.

Q20. Do any of the recent changes apply to the Medicare Diabetes Prevention Program (MDPP)?

Yes! CMS modified certain MDPP policies during the PHE:

- MDPP suppliers that have the capability can deliver MDPP services virtually. If MDPP suppliers cannot provide services virtually, CMS is allowing them to suspend in-person services and resume services at a later date.
- CMS is waiving limits on the number of virtual make up sessions for MDPP suppliers able to provide services virtually. These virtual services must be provided in a manner consistent with the CDC's DPRP standards for virtual sessions, follow the CDC approved DPP curriculum requirements, and are provided at the request of the Medicare beneficiary.
- Virtual make-up sessions may only be furnished to achieve attendance goals and may not be furnished to achieve weight-loss goals.
- Waiving the once per lifetime benefit and allow MDPP beneficiaries whose sessions were suspended to resume sessions or start over.
- Increasing the number of virtual make-up sessions that can be offered by MDPP suppliers.
- These changes are applicable only to MDPP suppliers that are enrolled in the MDPP as of March 1, 2020 and Medicare beneficiaries who were receiving services as of March 1, 2020. The requirement for in-person attendance at the first core session remains in effect.
- These changes are only in effect during the PHE.

Q21. Does this impact in-person/ face-to-face requirements for CGM and insulin pumps?

In their March 30 interim final rule (IFR), CMS announced that they were waiving the face-to-face requirements for evaluations, assessments, certifications, etc. outlined in national coverage determinations (NCDs) and local coverage determinations (LCDs) during the COVID-19 pandemic. The face-to-face requirements for insulin pumps and continuous glucose monitoring systems (CGM) had created issues for providers and people with diabetes during the PHE.

Q22. Has CMS made any other announcements about CGM?

Yes! On April 30, CMS announced they will not enforce the clinical indications for CGM in local coverage determinations (LCDs). At this time, this change only applies during the PHE for the COVID-19 pandemic. CMS has stated that they will not enforce the current clinical indications restricting the type of diabetes that a beneficiary must have to be eligible for CGM or the need to demonstrate frequent blood glucose testing to receive a Medicare covered CGM. We are seeking additional clarification to ensure this applies to all beneficiaries.

Q23. I am an approved telehealth provider (RDN at this time) and I'm set up to do telehealth. Should I bill on the CMS 1500 or CMS 1450 (UB-04)? What are my options?

DSMT is paid under the Medicare Physician Fee Schedule and as such, many programs utilize the CMS 1500 form for billing. We are aware that some programs that submit claims for DSMT via the CMS 1450 (UB-04) per the instructions in the Medicare Benefit Policy Manual. Though largely resolved (see questions 9 and 10), some programs have reported challenges in billing telehealth services via the UB-04. This is ultimately a decision that needs to be made by your facility, but you may consider using the CMS 1500 form if possible.