E-BRIEF SERIES

Risk Adjustment Telehealth Guide

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Introduction

With the rapid expansion of telehealth services — due to the Public Health Emergency (PHE) that began in early 2020 — we have now had one full year of the "new normal" under our belts. According to Health and Human Services, we can bask in the telehealth light through at least July 23, 2021, and possibly through the end of the year. This PHE has had a significant impact on Risk Adjustment organizations and payers.

In 2020 we saw a postponement of both HCC submissions (for the 2019 calendar year) and 2019 Risk Adjustment Data Validation (RADV) audits. This was in response to the mass effort both HHS and CMS were implementing due to the global pandemic and its economic impacts. 2021 will pose a challenge to some organizations and plans as it will be a dual submission year. HHS has rolled out an updated RADV timeline for both CY 2019 and CY 2020 submissions.

With the postponement coming to an end, are you "in the know" on your telehealth risk adjustment requirements and guidance?

Medicare Advantage, Cost, PACE, and Demonstration Organizations

According to the Applicability of Diagnoses from Telehealth Services for Risk Adjustment, CMS expanded their telehealth services for Medicare Advantage, Cost, PACE, and demonstration organizations. However, they do require submissions be "provided using an interactive audio and video telecommunications system that permits real-time interactive communication."

The foundation of an acceptable risk adjustment encounter is an acceptable face-to-face encounter from an acceptable documentation source and provider type and specialty. Audio and video visits still fulfill those requirements. Medicare does not accept telephone-only visits as a valid risk adjustment documentation source as they do not fulfill the face-to-face requirement.

HHS-Operated Risk Adjustment Programs

CMS published an FAQ sheet for Risk Adjustment Telehealth and Telephone Services during COVID-19 in April 2020 and updated it in August 2020. Like the telehealth services for Medicare Advantage organizations noted above, the services must be "descriptive of a face-to-face service furnished by a qualified healthcare professional and is an acceptable source of new diagnoses." The FAQ goes on to specify: "Telehealth visits are considered equivalent to face-to-face interactions, but they are still subject to the same requirements regarding provider type and diagnostic value." The table below breaks down acceptable HHS telehealth services:

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient	• G0425 – G0427 (Telehealth consultations, emergency department, or initial inpatient) • G0406 – G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNF's) • G0459 – (Inpatient telehealth pharmacologic management) • G0508 – G0509 (Critical care telehealth communicating with providers and patients)	For new or established patients
E-VISITS	A communication between a patient and their provider through an online patient portal	• 98970 – 98972 (*Patient initiated – Qualified Non-physician health care professional online digital E/M service up to 7 days.) • 99421 – 99423 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days) • G2061 – G2063 (Valid for 2020 DOS only)	Established patients
TELEPHONE VISITS	Non face-to-face E/M	• 98966 – 98968 (other qualified professional, PT, OT, LCSW, etc) • 99441 – 99443 – (Physician / Mid-Level)	Established patients

Whether you're submitting telehealth diagnoses for CMS or HHS, the place of service in the EDS/RAPS system must be an "02" designating the visit as telehealth or the modifier listed as "95" with any place of service code identifying a telemedicine service was rendered via a real-time interactive audio and video telecommunications system or telephone service.

Will Telehealth Stay Around?

The expansion of telehealth due to COVID opened the floodgates of technology and advancements that, in my opinion, will not go away anytime soon. The quick adaptation has resulted in a knowledge that things can be done differently. I believe there will be limitations and guidelines reinstated. However, the door of telehealth can never be fully shut again. And it would be best for organizations and payers to research state and federal restrictions, ask questions, and develop their own telehealth sections for their risk adjustment audit and compliance plans — to stay ahead of the curve on changes and auditing.

Telehealth is not going away any time soon.

References

- 2019 Benefit Year HHS-RADV Activities Timeline
- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
- Risk Adjustment Telehealth and Telephone Services During COVID-19 FAQ's – updated August 3, 2020 Medicare Telemedicine Health Care Provider Fact Sheet
- Center for Connected Health Policy
- Applicability of Diagnoses from Telehealth Services for Risk Adjustment

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Jennifer Hill, CPC, CPMA, CRC is a risk adjustment specialist who has worked on a variety of client projects both big and small, from Medicare to private insur-ance companies. Currently, Jennifer serves as Regional Director of AAPC Services, where she uses her passion for project management, coding and auditing to develop curriculum and provide quality education and training to coders, auditors and providers across the country.

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