

AHCA FAQs: SNF Therapy Telehealth Under COVID-19 Section 1135 Waivers

Q.1. – Do the COVID-19 Section 1135 telehealth waivers permit physical and occupational therapy and speech-language pathology services to be delivered via telehealth technology?

A.1. – Yes. The [COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers](#) (excerpt below) waived existing statutory and regulatory exclusions for who could be considered an “*eligible practitioner*” during the COVID-19 public health emergency (PHE), and stated that health care “*professionals*” including “*physical therapists, occupational therapists, speech-language pathologists, and others*” can receive payment for Medicare telehealth services.

Flexibility for Medicare Telehealth Services

- **Eligible Practitioners.** Pursuant to authority granted under the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) that broadens the waiver authority under section 1135 of the Social Security Act, the Secretary has authorized additional telehealth waivers. CMS is waiving the requirements of section 1834(m)(4)(E) of the Act and 42 CFR § 410.78 (b)(2) which specify the types of practitioners that may bill for their services when furnished as Medicare telehealth services from the distant site. The waiver of these requirements expands the types of health care professionals that can furnish distant site telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services.

Q.2. – I’ve heard on prior CMS COVID-19 calls and from consultants that CMS only permits therapy telehealth services to be billed by therapists under Medicare Part B if they are in private practice on a CMS 1500 claim form, or for therapy services furnished by a hospital outpatient therapy department using a UB-04 (CMS 1450) claim form - Do the COVID-19 Section 1135 telehealth waivers permit physical and occupational therapy and speech-language pathology services furnished by SNF providers to be delivered via telehealth technology and paid under Medicare Part B?

A2. – Yes. On May 27, 2020 CMS posted an update to coverage and billing guidance impacting SNF related to COVID-19 Section 1135 waivers [here](#). The document’s section *FF Outpatient Therapy Services Q&A #1* (excerpt below) indicates that all facility-based providers can bill for Part B therapy services furnished via telehealth and provides specific claims processing guidance. Specifically to SNF, it provides guidance that to identify when a Part B therapy telehealth service under the 1135 waiver was furnished, the SNF outpatient revenue centers 22X or 23X on the UB-04 (CMS-1450) claim are used, and SNF billers must also append a -95 modifier to the claim lines for such services (in addition to traditional therapy discipline and other modifiers).

FF. Outpatient Therapy Services

1. **Question:** Can outpatient therapy services that are furnished via telehealth and separately paid under Part B be reported on an institutional claim (e.g., UB-04) during the COVID-19 PHE?

Answer: Yes, outpatient therapy services that are furnished via telehealth, and are separately paid and not included as part of a bundled institutional payment, can be reported on institutional claims with the “-95” modifier applied to the service line. This includes:

- Hospital – 12X or 13X (for hospital outpatient therapy services);
- Skilled Nursing Facility (SNF) – 22X or 23X (SNFs may, in some circumstances, furnish Part B physical therapy (PT)/occupational therapy (OT)/speech-language pathology (SLP) services to their own long-term residents);
- Critical Access Hospital (CAH) – 85X (CAHs may separately provide and bill for PT, OT, and SLP services on 85X bill type);
- Comprehensive Outpatient Rehabilitation Facility (CORF) – 75X (CORFs provide ambulatory outpatient PT, OT, SLP services);
- Outpatient Rehabilitation Facility (ORF) – 74X (ORFs, also known as rehabilitation agencies, provide ambulatory outpatient PT & SLP as well as OT services); and
- Home Health Agency (HHA) – 34X (agencies may separately provide and bill for outpatient PT/OT/SLP services to persons in their homes only if such patients are not under a home health plan of care).

New: 5/27/20

Q.3. – Can a SNF use telecommunications technology to furnish telehealth PT, OT, or SLP services to a Medicare Part A resident and separately bill Medicare Part B for the services?

A.3. – Yes and No. While telehealth technology can be used to furnish therapy services under Part A during the PHE, such services are not separately payable due to SNF PPS consolidated billing requirements. On May 27, 2020 CMS posted an update to coverage and billing guidance impacting SNF related to COVID-19 Section 1135 waivers [here](#). This specific question was addressed in section *FF Outpatient Therapy Services Q&A #2* (excerpt below)

FF. Outpatient Therapy Services

2. **Question:** Can therapy services furnished using telecommunications technology be paid separately in a Medicare Part A skilled nursing facility (SNF) stay?

Answer: Provision of therapy services using telecommunications technology (consistent with applicable state scope of practice laws) does not change rules regarding SNF consolidated billing or bundling. For example, Medicare payment for therapy services is bundled into the SNF Prospective Payment System (PPS) rate during a SNF covered Part A stay, regardless of whether or not they are furnished using telecommunications technology.

Therapy services furnished to a SNF resident, whether in person or as telehealth services, during a non-covered SNF stay (Part A benefits exhausted, SNF level of

care requirement not met, etc.) must be billed to Part B by the SNF itself using bill type 22X, regardless of whether or not they are furnished using telecommunications technology.

New: 5/27/20

Q.4. – Are there specific Medicare Part B therapy codes that are permitted to be furnished and billed as telehealth services during the COVID-19 PHE?

A.4. – Yes. In the April 6, 2020 Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID–19 Public Health Emergency, [Interim final rule](#) with comment period 85 FR 19239, CMS added the following 21 therapy services Current Procedural Terminology (CPT) codes to the approved category 2 telehealth service list:

- **97161** (Physical therapy evaluation: low complexity...Typically, 20 minutes are spent face-to-face with the patient and/or family.)
- **97162** (Physical therapy evaluation: moderate complexity...Typically, 30 minutes are spent face-to-face with the patient and/or family.)
- **97163** (Physical therapy evaluation: high complexity...Typically, 45 minutes are spent face-to-face with the patient and/or family.)
- **97164** (Re-evaluation of physical therapy established plan of care...Typically, 20 minutes are spent face-to-face with the patient and/ or family.)
- **97165** (Occupational therapy evaluation, low complexity...Typically, 30 minutes are spent face-to-face with the patient and/or family.)
- **97166** (Occupational therapy evaluation, moderate complexity...Typically, 45 minutes are spent face-to-face with the patient and/or family.)
- **97167** (Occupational therapy evaluation, high complexity...Typically, 60 minutes are spent face-to-face with the patient and/or family.)
- **97168** (Re-evaluation of occupational therapy established plan of care...Typically, 30 minutes are spent face-to-face with the patient and/or family.)
- **97110** (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility)
- **97112** (Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities)
- **97116** (Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
- **97535** (Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes)
- **97750** (Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes)
- **97755** (Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes)

- **97760** (Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes)
- **97761** (Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes)
- **92521** (Evaluation of speech fluency (eg, stuttering, cluttering))
- **92522** (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria))
- **92523** (Evaluation of speech sound production (eg, articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (eg, receptive and expressive language))
- **92524** (Behavioral and qualitative analysis of voice and resonance)
- **92507** (Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual)

Q.5. – Can a SNF physical therapist assistant (PTA) or occupational therapy assistant (OTA) furnish therapy services via telehealth?

A.5. – Yes. As per the CMS blanket waiver cited in Q.1. above, CMS waived the current statutory definition of eligible telehealth practitioners and added that health care “professionals” including “physical therapists, occupational therapists, speech-language pathologists, and others” can receive payment for Medicare telehealth services for the duration of the PHE. The current definition of a “qualified professional” able to furnish outpatient therapy services in [Chapter 15](#), Section 220 of the Medicare Benefit Policy Manual (excerpt below) indicates that a “qualified professional” may also include a properly supervised physical therapist assistant (PTA) or an occupational therapy assistant (OTA).

220 - Coverage of Outpatient Rehabilitation Therapy Services (Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services) Under Medical Insurance (Rev.255, Issued: 01-25-19, Effective: 01- 01- 19, Implementation: 02-26-19)

QUALIFIED PROFESSIONAL means a physical therapist, occupational therapist, speech-language pathologist, physician, nurse practitioner, clinical nurse specialist, or physician’s assistant, who is licensed or certified by the state to furnish therapy services, and who also may appropriately furnish therapy services under Medicare policies. Qualified professional may also include a physical therapist assistant (PTA) or an occupational therapy assistant (OTA) when furnishing services under the supervision of a qualified therapist, who is working within the state scope of practice in the state in which the services are furnished.

Q.6. – How would a SNF bill for a Part A resident that received telehealth services from a therapy qualified professional who was at a remote location?

A.6. – There is no separate billing. As per the May 27, 2020 CMS updated coverage and billing guidance impacting SNF related to COVID-19 Section 1135 waivers, specifically section FF Outpatient Therapy Services Q&A #2 (see Q.3. above), while telehealth technology can be used to furnish therapy services under Part A, such services are not separately payable due to

SNF PPS consolidated billing requirements. However, the documentation should indicate those services furnished via telecommunications versus those furnished face-to-face.

Q.7. – Can a SNF bill a telehealth originating site code for Part B therapy services furnished via telehealth from a therapy professional at a different location and for the therapy service procedures furnished?

A.7. – No. Based on similar scenarios posed during public COVID-19 calls, it appears that in such circumstances a provider would not be able to bill the originating site fee if they are also billing for the telehealth therapy services. This is different than for physician telehealth services where the SNF is able to submit claims for the originating site fee if the physician is furnishing telehealth services from a remote location.

Q.8. – I see that physicians and therapists in private practice are required to include a place of service (POS) code on the CMS 1500 claims for telehealth services. SNFs submit claims using UB-04 (CMS 1450) claim forms that do not have a field for POS. Do SNF's need to code POS on a Part B claim when reporting therapy telehealth services during the COVID-19 PHE?

A.8 – No. Section *FF Outpatient Therapy Services* in the May 27, 2020 CMS [update](#) to coverage and billing guidance impacting SNF related to COVID-19 Section 1135 waivers identified that only the -95 claim line modifier code is required to indicate those Part B therapy services furnished by telehealth.

Q.9. – My SNF is licensed in my state to also furnish outpatient therapy services to beneficiaries residing in the community, including assisted living and independent living residences, typically after discharge from a Medicare Part A stay. Under the COVID-19 Section 1135 outpatient therapy telehealth blanket waiver, can we furnish telehealth services under Part B to these patients if we are unable to see them face-to-face due to COVID-19 infection control guidance?

A.9. – Yes. If a SNF is certified by the state to furnish outpatient therapy services to beneficiaries residing in the community and is able to bill Medicare Part B for these services, then under the Section 1135 therapy telehealth blanket waiver the SNF can furnish permitted outpatient therapy telehealth codes (see Q.4. above) using the same SNF revenue center, as long as the -95 telehealth modifier is appended to the claim line(s) (as per Q.2. above)

Q.10. – Can a resident in an assisted living residence receive outpatient therapy telehealth services under the COVID-19 Section 1135 blanket waiver from any outpatient therapy provider that they would have been able to see prior to the PHE?

A.10. – Yes. On May 27, 2020 CMS posted an update to coverage and billing guidance impacting SNF related to COVID-19 Section 1135 waivers [here](#). The document's section *FF Outpatient Therapy Services Q&A #1* (see Q.2. above) indicates that in addition to physicians, non-physician practitioners and therapists in private practice, all facility-based providers can bill for permitted Part B therapy telehealth services (see Q.4. above) that they would have furnished otherwise prior to the COVID-19 PHE. This includes outpatient hospital therapy departments,

SNFs, critical access hospitals, home health agencies (if beneficiary not under a HH Part A plan of care), rehabilitation agencies, and CORFs.

Q.11. – Can a provider furnish and bill for maintenance therapy services under the COVID-19 Section 1135 outpatient therapy telehealth waivers?

A.11. Yes. The COVID-19 Section 1135 outpatient therapy telehealth waivers did not change basic Medicare skilled care coverage requirements. Skilled maintenance therapy services are covered services and use the same procedure codes as therapy furnished to improve function. Please refer to the Medicare Benefit Policy Manual, [Chapter 15](#), Section 220.2.D for more details regarding the definition of reasonable and necessary skilled maintenance programs.

Below is a selection of relevant COVID-19 Section 1135 Telehealth Waiver Billing FAQs most recently revised 5/27/2020 that SNF providers should review related to applying the therapy telehealth waivers. The complete CMS FAQ document may be found [here](#).

Section L. Medicare Telehealth (Please note that these FAQs do not include flexibilities that might be exercised under the CARES act)

1. Question: What services can be provided by telehealth during a waiver for the public health emergency (PHE) declared by the Secretary under the section 1135 waiver authority?

Answer: Medicare telehealth services include many services that are normally furnished in-person. CMS maintains a list of services that may be furnished via Medicare telehealth. This list is available here: <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by physicians and certain non-physician practitioners regardless of the patient's location. Medicare also pays for certain other services that are commonly furnished remotely using telecommunications technology, but are not considered Medicare telehealth services. These services can always be provided to patients wherever they are located, and include physician interpretation of diagnostic tests, care management services, and virtual check-ins.

New: 4/9/20

3. Question: Is any specialized equipment needed to furnish Medicare telehealth services?

Answer: Currently, CMS allows telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication, they qualify as acceptable technology. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>.

New: 4/9/20

4. Question: Can practitioners provide Medicare telehealth services using their phones?

Answer: Yes, for use of certain phones. Section 1135(b)(8) of the Social Security Act allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. Additionally, CMS amended its regulations through the IFC to remove the potential perception of restrictions on technology that practitioners can use to provide telehealth services. The Office of Civil Rights has also issued guidance allowing covered health care providers to use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk of penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency. For more information: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html>.

New: 4/9/20

6. Question: How much does Medicare pay for telehealth services?

Answer: Medicare pays the same amount for telehealth services as it would if the service were furnished in person.

New: 4/9/20

7. Question: How long will practitioners be able to bill using these new flexibilities?

Answer: The telehealth waiver will be effective until the end of the PHE declared by the Secretary of HHS on January 31, 2020. Billing for the expanded Medicare telehealth services, as well as for the telephone assessment and management, telephone, evaluation and management services, and additional flexibilities for communications technology-based services (CTBS) are effective beginning March 1, 2020, and through the end of the PHE.

New: 4/9/20

8. Question: Can physicians and practitioners let their patients know that Medicare covers telehealth in new locations during the PHE?

Answer: Yes. Physicians and practitioners should inform their patients that services are available via telehealth in new locations, including their homes, during the PHE and educate them on any applicable cost sharing.

New: 4/9/20

9. Question: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?

Answer: Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a “distant site”), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure

risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

New: 4/9/20

10. Question: How are telehealth services different from virtual check-ins and e-visits? How much does Medicare pay for these services?

Answer: Medicare telehealth services are services that would normally occur in person but are instead conducted via telecommunications technology and are paid at the full in-person rate. Service such as the virtual check-in, eVisits, remote evaluation, and telephone visits are not services that would normally occur in person, and are not paid as though the service occurred in person. A virtual check-in lets professionals bill for brief (5-10 min) communications that mitigate the need for an in-person visit and can be furnished via any synchronous telecommunications technology visit that would be furnished along with an evisit is similar to a virtual check-in, but should be reported when a beneficiary communicates with their health care provider through an online patient portal. Telephone visits may be furnished via audio-only telephone whereas the remote evaluation describes the evaluation of a prerecorded video or image provided by the patient. *AHCA Note:* See CMS [FAQ](#) for Table 1 for a list of virtual check-in codes.

New: 4/9/20

12. Question: Can other practitioners who do not bill for E/M codes provide communication technology-based services (e.g. remote evaluation of patient images/video and virtual check-in) or telephone assessment and management services during the PHE?

Answer: Yes. During the PHE, the availability of HCPCS codes G2010 and G2012 is broadened to allow certain practitioners, such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers, and clinical psychologists, who do not report E/M codes to bill for these services. CMS has also activated CPT codes 98966, 98967, and 98968, which describe assessment and management services conducted over the phone.

New: 4/9/20

26. Question: Do Medicare telehealth services require CR (“catastrophe/disaster related”) modifier and/or DR (“disaster related”) condition code?

Answer: No, the CR and DR modifiers are not necessary for Medicare telehealth services.

New: 5/27/2020

28. Question: How should telehealth services be documented in the medical record (e.g., face-to-face time, preparation time)?

Answer: We expect the same level of documentation that would ordinarily be provided if the services furnished via telehealth were conducted in person.

New: 5/27/2020

33. Question: Are services designated on the telehealth list as non-covered by Medicare eligible for payment during the PHE?



Answer: No. Services that are currently non-covered remain so unless subsequent rulemaking is undertaken to make them covered services. These services were added to the telehealth list for informational purposes only, to reflect stakeholder requests.

New: 5/27/2020