AQREVA
Medical Billing & Consulting

Client Memo
March 2020

"The way to get started is to quit talking and begin doing."

-- Walt Disney

NEWS Update

Hot Off the Press!!

Providers have until the end of March 2020 to submit their data for the MIPS 2019 performance year.

Emails from Health Services Advisory Group and other CMS contracted Quality Innovation Network-Quality Improvement Organizations have been going out to MIPS eligible providers who have not yet submitted 2019 MIPS data, reminding them of the 7% penalty they face in 2021.

It is too late to submit quality measures via claims. Data can still be submitted through your EHR.

One of the ways providers can still submit MIPS data and avoid a penalty is by signing up with a CMS approved qualified registry:

1. Report at least one patient visit for each of the six quality measures you selected; and

2. Report2 medium or 1 high-weighted improvement activity that was completed for 90 Days.

This will give you the 30 points you need to avoid the 7% penalty in 2021.

MIPS qualified registries such as Healthmonix (MIPS Pro), MD Interactive, or MIPS Wizard are authorized by CMS to submit Quality Measures, Promoting Interoperability Measures and/or Improvement Activities on behalf of MIPS eligible providers, groups, and/or virtual groups for a fee. A complete list of qualified registries can be found at:

https://www.aana.com/docs/default-source/quality-aana.com-web-documents-(all)/2019-qualified-registry-posting_final.pdf?sfvrsn=4c4d51b1_2

Deadlines for submitting data to a qualified registry vary.

QPP Website Now Includes Important Information on 2020 MIPS Measures

CMS has updated the "Explore Measures Tool" on the Quality Payment Program (QPP) website for the 2020 performance period. The tool now includes 2020 MIPS measures and activities for the four performance categories:

- Quality
- Cost
- Improvement Activities (IA)
- Promoting Interoperability (PI)

CMS has updated the QPP Participation Status Lookup Tool with initial 2020 eligibility information.

Low-Volume Threshold Requirements

To be eligible to participate in MIPS in 2020, you must:

Bill more than $90,000 a year in allowed charges for covered professional services under the Medicare Physician Fee Schedule (PFS),

AND

Furnish covered professional services to more than 200 Medicare Part B beneficiaries,

AND

Provide more than 200 covered professional services under the PFS.

How CMS Determines Your 2020 MIPS Eligibility Status
CMS reviews both PECOS data and Medicare Part B claims for services provided during two 12-month segments called the MIPS determination period:

1) October 1, 2018–September 30, 2019
2) October 1, 2019–September 30, 2020

The current QPP Participation Status Tool update shows your preliminary 2020 eligibility status based on data from October 1, 2018–September 30, 2019.

CPT Code 99483: What is it?

Providers can be reimbursed for providing care planning services to individuals with cognitive impairment, including Alzheimer's disease, by using CPT code 99483.

Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse midwives can currently bill under this code.

All beneficiaries who are cognitively impaired are eligible to receive the services under the code. This includes those who have been diagnosed with Alzheimer's, other dementias, or mild cognitive impairment. But, it also includes those individuals without a clinical diagnosis who, in the judgment of the clinician, are cognitively impaired.

Service Elements of 99483

Cognition-focused evaluation, including a pertinent history and examination of the patient
Medical decision making of moderate or high complexity (defined by the E/M guidelines)
Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity
Use of standardized instruments to stage dementia
Medication reconciliation and review for high-risk medications, if applicable
Evaluation for neuropsychiatric and behavioral symptoms, including depression and including use of standardized instruments
Evaluation of safety (for example, home safety), including motor vehicle operation, if applicable
Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports and the willingness of the caregiver to take on caregiving tasks
Development, updating or revision, or review of an Advance Care Plan
Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs and support groups); the care plan must be shared with the patient and/or caregiver at the time of initial education and support

Can the care planning be provided over the phone?

No. Services under 99483 require a proper history from a corroborating or independent source (such as a family member or caregiver) and must be provided face-to-face with the beneficiary in a physician's office, outpatient setting, home, domiciliary, or rest home.

How often can care planning be provided?

Clinicians can provide and bill for care planning services under 99483 once every 180 days. Experts have noted that care planning for individuals with dementia is an ongoing process and that a formal update to a care plan should occur at least once per year.

In revising a care plan, clinicians could utilize one of the E/M codes, such as for chronic care management. Also, Medicare now has an E/M code specifically for non-face-to-face consultations, which means updating a care plan could be done over the phone or internet.

Are there any restrictions in using other billing codes at the same time as 99483?

Some of the service elements under 99483 overlap with services under some E/M codes, advance care planning services, and certain psychological or psychiatric service codes. As a result, 99483 cannot be used along with the following codes: 90785, 90791, 90792, 96103, 96120, 96127, 99201-99215, 99241-99245, 99324-99337, 99341-99350, 99366-99368, 99497, 99498, and 96161.

How much will clinicians be reimbursed under the new code?

Reimbursement rates can vary slightly based on the setting in which the service is provided and geographic location. 99483, billed by a physician in a non-facility setting, would be approximately $258 for 2020.

How exactly should clinicians conduct a visit under the code?

The Alzheimer's Association developed a toolkit to educate providers about using this billing code with their patients. The tool kit includes best practices on conducting a visit under 99483.

A copy of the toolkit, as well as additional information, is available at:

https://alz.org/professionals/health-systems-clinicians/care-planning

EHR Scribe Tools

The implementation of an EHR scribe tool has made life easier for clinicians, resulting in shorter workdays and more family time, writes Christopher Jason in his article, "How EHR Scribe Tools Lessen Clinician Burnout, Cognitive Workload." (*EHR Intelligence.com,* February 28, 2020)

"When you put something in between the doctor and the patient that doesn't help them and may even hinder their ability to help the patient, that is what triggers burnout," explained Mark Grenitz, MD in an interview with *EHRIntelligence.com.*

For the internist at his practice, the EHR caused significant delays in patient care. The provider was struggling because he was always at least an hour behind during office hours due to the 10 or 15 minutes spent charting before he moved on to the next patient.

Hired scribes are a way to lessen clinician burnout and improve documentation. These workers have been around just as long as the EHRs themselves, but have been fraught with issues.

Medical offices would typically hire a medical student to shadow the clinician and type information into the EHR. But these student scribes did not know how to write proper progress notes, and most weren't great at picking out the key parts of the conversation. If the scribe is not a fast typist or doesn't have a good memory, the scribe could miss important information.

Dr. Grenitz and his team adopted an EHR scribe technology called Scribble, provided by IKS Health, which he described as "**scribes on steroids."**

The tool records the visit from start to finish. Once the patient visit is complete, the medical professional can read the transcript and cut out the unimportant parts of the conversation to create a progress note. The next time the patient returns for a visit, the clinician can quickly view the bullet points to read the salient information.

Scribble: a virtual scribe solution

Scribble is an asynchronous virtual scribe service that pairs physicians with a Virtual Physician Partner (VPP) who creates an accurate, comprehensive clinical note for each patient visit.

https://www.ikshealth.com/scribble

Digital Health Tools Gain Momentum –

Robert Mills, *AMA-Assn.org,* February 6 , 2020

Adoption of digital health tools has grown significantly among all physicians since 2016. New AMA research shows more physicians than ever recognize digital health tools as an advantage for driving improved efficiency and safety in health care.

The AMA Digital Health Research investigates shifts in physician adoption of digital health tools during the last three years, along with current attitudes and expectations among physicians.

The research examines seven categories of digital health tools that engage patients for clinical purposes, interpret and use clinical data, and manage outcomes and other measures of care quality.

Adoption trends in the following seven categories are helping to propel the digital transformation of health care.

1. Tele-visits/virtual visits – This category showed the largest growth in physician adoption, jumping from 14% in 2016 to 28% in 2019 and includes audio/video connections used to see patients remotely.

2. Remote monitoring and management for improved care – Jumping from 13% in 2016 to 22% in 2019, this category includes mobile applications and devices for use by chronic disease patients for daily measurement of vital signs, such as weight, blood pressure, blood glucose, etc.

3. Remote monitoring for efficiency – Physician adoption grew modestly from 12% in 2016 to 16% in 2019 for this category which includes smart versions of common clinical devices such as thermometers, blood pressure cuffs, and scales that automatically enter readings in the patient medical record.

4. Clinical decision support – This category climbed from 28% in 2016 to 37% in 2018 and includes modules used in conjunction with the EHR, or mobile applications integrated with an EHR, that highlight potentially significant changes in patient data, such as weight gain/loss, change in blood chemistry, etc.

5. Patient engagement – Physician adoption rose from 26% in 2016 to 32% in 2019. This category includes solutions to promote patient wellness and active participation in their care for chronic diseases, such as adherence to treatment regimens.

6. Point of care/workflow enhancement - Physician adoption modestly increased from 42% in 2016 to 47% in

2019. This category includes communication and sharing of electronic clinical data to consult with specialists, make referrals and/or transitions of care.

7. Consumer access to clinical data – Physician adoption rose from 53% in 2016 to 58% in 2019, the highest adoption rate among the digital health tool categories. This category includes secure access allowing patients to view clinical information such as routine lab results, receive appointment reminders and treatment prompts, and to ask for prescription refills, appointments and to speak with their physician.

Driving this adoption is a significant increase in the importance physicians place in providing remote care to patients.

To speed implementation of remote patient monitoring, the AMA's Digital Health Implementation Playbook packages the key steps, best practices and resources to help physicians extend care beyond the exam room.

Learn more on how the AMA is assisting physicians in using advanced technologies by visiting their digital health website:
https://www.ama-assn.org/practice-management/digital

Reporting 2020 MIPS Quality Measures via Part B Claims: Quick Start Guide for Small Practices – CMS, February 27, 2020

CMS has issued a new interactive guide for small practices to assist them in reporting their 2020 Quality Measures through Part B Claims. A small practice is defined as a group that has 15 or few clinicians billing under the group's TIN.

The guide can be obtained at:
file:///C:/Users/seng/Downloads/2020%20Part%20B%20Claims%20Reporting%20Quick%20Start%20Guide.pdf

How to get started:

- Use the 2020 Quality Payment Program (QPP) Medicare Part B Claims Measures Single Source document to search for encounter, procedure, and diagnosis codes that you routinely bill.
- Under the Explore Measures & Activities Tool on the QPP website, search for key terms that are applicable to the care that you provide or patient population you serve or filter by specialty set.
- QPP Website: https://qpp.cms.gov

Select 6 measures for the group as a whole or 6 measures for each MIPS eligible clinician. *Of these 6 measures, 1 must be an outcome measure OR a high-priority measure (if an outcome measure is not available).*

The data completeness threshold increased to 70% for the 2020 performance period, from 60% in 2019. For Medicare Part B claims measures, this means that you must report performance data for at least 70% of your Medicare Part B patients that qualify for the measure.

Small practices will continue to get 3 points for quality measures that don't meet the data completeness requirement.

Coding for Coronavirus COVID-19

The Centers for Disease Control and Prevention has released the following document to provide official diagnosing coding guidance for health care encounters and deaths related to the 2019 COVID-19 coronavirus.

This guidance is intended to be used in conjunction with the current ICD-10-CM classification and the ICD-10-CM Official Guidelines for Coding and Reporting (effective October 1, 2019) and will be updated to reflect new clinical information as it becomes available.
https://www.cdc.gov/nchs/data/icd/10cmguidelines-FY2020_final.pdf.

The ICD-10-CM codes provided in this document are intended to provide information on the coding of encounters related to coronavirus. Other codes for conditions unrelated to coronavirus may be required to fully code these scenarios in accordance with the ICD-10-CM Official Guidelines for Coding and Reporting. A hyphen is used at the end of a code to indicate that additional characters are required.

Pneumonia
For a pneumonia case confirmed as due to the 2019 novel coronavirus (COVID-19), assign codes:

J12.89, Other viral pneumonia, and
B97.29, Other coronavirus as the cause of diseases classified elsewhere

Acute Bronchitis
For a patient with acute bronchitis confirmed as due to COVID-19, assign codes:

J20.8, Acute bronchitis due to other specified organisms, and
B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Bronchitis not otherwise specified (NOS) due to the COVID-19 should be coded using:

J40, Bronchitis, not specified as acute or chronic; along with code

B97.29, Other coronavirus as the cause of diseases classified elsewhere.

ARDS

Cases with ARDS due to COVID-19 should be assigned the following codes:

J80, Acute respiratory distress syndrome, and

B97.29, Other coronavirus as the cause of diseases classified elsewhere.

Exposure to COVID-19

For cases where there is a concern about a possible exposure to COVID-19, but this is ruled out after evaluation, it would be appropriate to assign the code **Z03.818,** Encounter for observation for suspected exposure to other biological agents ruled out.

For cases where there is an actual exposure to someone who is confirmed to have COVID-19, it would be appropriate to assign the code **Z20.828,** Contact with and (suspected) exposure to other viral communicable diseases.

If the provider documents "suspected", "possible" or "probable" COVID-19, do not assign code B97.29. Assign a code(s) explaining the reason for encounter (such as fever, **or Z20.828**).

This coding guidance has been developed by the CDC and approved by the four organizations that make up the Cooperating Parties: the National Center for Health Statistics, the American Health Information Management Association, the American Hospital Association, and CMS.

Coding Experts Share Their Top E/M Tips

Lisa Eramo has compiled a list of "Top E/M tips to boost revenue and mitigate compliance risk" in her January 30, 2020 article for *Medical Economics.* Experts were asked to share their best documentation tips to ensure accurate E/M reporting.

History - Physicians frequently forget to include all of the elements necessary for the E/M level they're billing, often leading payers to down-code these services to a lower level.

That means physicians could lose as much as $133 per encounter, says Toni Elhoms, CCS, CPC, CEO of Alpha Coding Experts, LLC.

Be as descriptive as possible when documenting the HPI. Specify the location, quality, severity, timing, context, modifying factors, and associated signs and symptoms that are significantly related to the presenting problem, says Sonal Patel, CPMA, CPC, a healthcare coder and compliance consultant with Nexsen Pruet LLC.

Don't repeat the same HPI for every visit. This is true even for follow-up appointments related to chronic conditions. Repeating the HPI could be a red flag that a physician is cloning their documentation, she adds.

Exam - Only review body areas or organ systems that affect MDM for the current encounter, says Michael Miscoe, JD, CPC, founding partner of Miscoe Health Law LLC in Central City, Pa. Most subsequent visits, for example, don't require a multi-system exam even though it's very easy in an EHR to pull this information forward from the initial visit.

Doing so inflates the E/M level and could expose a physician to audit risk, he adds.

Explain negative findings. Physicians who don't explain their analysis in the context of the patient's complaints often end up with what Miscoe terms "healthy sick people records" (i.e., level 4s and 5s with mostly negative findings and no explanation of why the physician performed certain services) that tend to raise a red flag with payers and auditors.

MDM - MDM is all about the cognitive labor a physician puts into the encounter, says Elhoms. This includes the number of diagnoses and management options considered, the amount and/or complexity of data reviewed (e.g., urinalysis, EKG, lab results, or additional workup planned), and the risk of complications, morbidity, or mortality.

Documenting each of these elements is critical because it can help justify a higher-level E/M code, she adds.

Time - Document the total time (in minutes) spent face-to-face with the patient and/or family during the visit, and specify how much time (in minutes) was spent counseling the patient and/or family or coordinating care, says Miscoe.

Watch out for underpayments

Experts agree that it's easy to forget that under-coding is also problematic because it results in revenue loss. Though less common, under-coding occurs when physicians report a lower than necessary E/M level out of fear they will be targeted by a payer for an audit. It can also happen when physicians don't document all the services they render or the complexity of their MDM.

Therapists Raise Concerns over PDPM

It's been four months into the Patient-Driven Payment Model (PDPM), and despite some industry analysts pointing to early gains for nursing homes, many occupational, speech, and physical therapy advocates continue to criticize layoffs and changes to resident care patterns, reports Lyndee Yamshon in her February 10, 2020, article "Pendulum Swung Too Far" for *Skilled Nursing News.*

On the operational side, the initial PDPM returns have been positive: For instance, 67% of nursing homes saw daily increases in Medicare per-day rates in November, according to the latest analysis from Zimmet Healthcare Services Group and its affiliated data firm, CORE Analytics.

But on the ground, the shift from a minutes-driven system to the new PDPM — with its incentives for group and concurrent therapy services — has been met with uproar from therapists who claim they're being undervalued.

Two therapy associations opted to find out exactly how therapists and administrators are faring with PDPM to date, and nearly 5,000 respondents didn't paint a positive picture.

Thousands of responses poured in, suggesting that fewer minutes and potentially inappropriate therapies lead to more complications for residents — while more therapists are being laid off and facing underemployment and increased work pressures, resulting in a serious morale problem.

The American Occupational Therapy Association (AOTA) and the American Speech-Language-Hearing Association (ASHA) collected about 600 and 4,435 responses to their surveys, respectively, and shared the feedback with SNN last week.

"One of the intentions of the new program is to do some correction and fine tuning of over-utilization, but we feel the pendulum [has] swung too far," Sharmila Sandhu, AOTA's vice president of regulatory affairs, said.

About 48% of occupational therapists claimed a nursing facility was mandating the provision of group or concurrent therapy in place of individual therapy, regardless of the patient's functional level under PDPM, Sandhu said.

"Our biggest concern is that we don't believe that…therapist[s'] clinical judgment should be overridden by policies," Sandhu said.

In addition to evolving clinical practices, about 50% of OTs and occupational therapy assistants reported being laid off or experiencing a reduction of working hours under PDPM.

With reduced therapy time and layoffs, the fear among therapists are "increases in falls … [and] readmissions to the hospital that are potentially preventable," Sandhu said. "And those are quality measures that these skilled nursing facilities … will be judged upon."

Although the goal is to get the patient healthier and back home as quickly as possible, many therapists like Sandhu insist that the timeline and care must be enacted safely and thoroughly before discharge.

When the federal government first introduced PDPM, the stated goal was to reduce providers' temptation to offer unnecessary therapy services solely for financial gain.

With PDPM, therapy shifted from a revenue driver to an expense for operators to manage while figuring out the complex new Medicare reimbursement math. In the immediate wake of the change, both confirmed and anecdotal reports of therapy layoffs roiled the industry, and a variety of voices cautioned operators against jerking the wheel too far in the other direction.

"I think it's really short-sighted that these companies are doing this, because they know CMS is watching, and they know if they have a dip in outcomes or dip in utilization, CMS is probably going to audit them," Kara Gainer, director of regulatory affairs for the American Physical Therapy association, said in October.

Mark Parkinson, president and CEO of the prominent nursing home industry trade group, the American Health Care Association, offered blunter warnings in conversation with SNN that same month.

"If we don't do better, we should be crushed by CMS," Parkinson said. "If therapy declines and outcomes decline, we deserve whatever penalty we get. But if therapy minutes decline and outcomes improve, we shouldn't be criticized, in my view."

The American Speech-Language-Hearing Association (ASHA) fielded a larger and more formal survey to more than 16,000 speech language pathologists (SLPs) who listed their primary or secondary employment setting as a nursing home.

Aside from standard demographic questions, the heart of the survey focused on changes in employment and clinical care as a result of PDPM.

When asked how PDPM impacts a clinician's employment status, 551 administrators and 3,411 clinicians responded, with 38% reporting reduced employment hours overall despite no official change in employment status — while

39% reported an increased productivity requirement for clinicians, and 21% observed a change in how productivity was calculated.

For administrators in the employment category, 40% responded that expectations of increased productivity requirements were the biggest impact since PDPM, and 21% indicated a change in how productivity was calculated.

In further commenting about the narrative trends, no one company was particularly problematic in implementing PDPM strategies in relation to therapy and patient care, said Monica Sampson, ASHA director of health care services in speech language pathology, but the overall changes pointed to a major reduction in therapy services.

More specifically, clinicians reported a trend of high-acuity residents not receiving enough individual care in the first few days, when it could be most needed.

Insiders Weigh In On PDGM

Andrew Donlan's article "Early Errors and Therapy Turmoil: Home Health Insiders Weigh In on PDGM's Arrival" for *Home Health Care News,* January 2, 2020, presents reactions on PDGM from home health industry leaders.

PDGM is finally here, marking the biggest home health reimbursement overhaul in two decades. With changes to billing periods, therapy reimbursement and LUPAs, it's the most significant shift since the Prospective Payment System (PPS) was implemented on Oct. 1, 2000, he writes.

PDGM will undoubtedly create major challenges for many in the industry. Either way, both concerned and optimistic players have geared up in anticipation of the new payment model.

Bill Dombi, President of the National Association for Home Care & Hospice (NAHC), states that Home health agencies have committed much to early preparation for PDGM. The greatest concern of the moment is whether CMS and its contractors are equally prepared. The skilled nursing facilities' experience in October with the Patient-Driven Payment Model (PDPM) is instructive, as there were a number of operational problems.

There are some core elements in the transformation to PDGM that are needed to optimize for chances of success:

- Gain control of revenue cycle management
- Engage in comprehensive, interdisciplinary clinical management
- Referral management
- Securing PDGM related benchmarking data on a near real-time basis, including both financial and clinical data that explain what the changes are that are ongoing within an HHA

Nick Seabrook, Managing Principal and Founder of BlackTree Healthcare Consulting, says that the biggest buzz they're hearing concerns errors with OASIS submissions to the iQIES system related to missing MBI numbers for Medicare Advantage patients, even for MA payers that have their own policy ID systems and don't require MBI's.

He believes that the biggest keys to the first month were what agencies did in the months leading up for preparation. In Mr. Seabrook's opinion, the two biggest keys in Month 1 of operations are managing cash flow and case conferencing. Timeliness and accuracy are crucial for both.

For cash flow to be properly managed, agencies should be managing their unbilled claims to keep that list as small as possible. It is inevitable that Medicare cash flow is going to take a dip early in 2020; agencies should remember to focus billing and collections efforts on non-Medicare payers to maximize cash flow coming in.

Furthermore, agencies should be getting clarification from their various MA payers on any updated billing and reimbursement rules. Agencies should be closely monitoring MA claims early under PDGM to ensure they are processing and paying properly.

David Hoover, Vice-President of Revenue Cycle Management at Axxess, stated they had PDGM-specific features in their software since May of 2019 and provided extensive training to clients about these features and the overall impact of PDGM.

The first month is all about getting your clinical and operational processes where they need to be quickly, he added. Make sure you're continuing to communicate to your clinicians, referral sources and the physicians signing orders. Your intake staff needs to be collecting a billable primary diagnosis. Clinicians need to be completing thorough and accurate OASIS assessments quickly.

Quality assurance reviews should be performed quickly to ensure accurate information is included in all documentation and any process breakdowns are identified. Be sure to communicate with physicians to ensure orders are signed timely.

You need all these things in place now so that you can bill the final claim at the end of the month.

MEDICARE NEWS

Medicare Coverage for Acupuncture

The finalized rule provides Medicare coverage for patients who require acupuncture and expands CMS's previous efforts to tackle the nationwide opioid crisis.

Under the finalized decision proposed back in July 2019, Medicare will now cover up to 12 acupuncture sessions in 90 days with an additional eight sessions for patients with chronic low back pain who show improvement.

The CMS announcement highlighted that patients 65 years of age or older who were enrolled in acupuncture studies showed improvement in function and pain.

HHS Secretary Alex Azar said in the January 21 announcement that expanding options for pain treatment is vital to steer patients away from opioid use and offer a potential alternative for patients with chronic low back pain.

SNF PDPM Claims Issue

Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM) initial claims that are processed out of sequence are not paying the correct Variable Per Diem (VPD)-adjusted rate. Also, all adjustment claims are not processing correctly. Claims need to process in date of service order for each stay for the VPD to calculate correctly. We will correct this issue in October. In the interim:

Submit claims in sequence by waiting at least 2 weeks before billing subsequent claims

To adjust claims, cancel the initial claim and all subsequent claims in the SNF stay then rebill in sequential order; or, hold adjustments (when allowable) until October when they will process correctly.

We encourage you to submit a complete bill at the time of entry.

Medicare Telehealth Payment Eligibility Organizer

The department of Health & Human Services (HRSA) has released a tool for providers to check if an address is eligible for a Medicare telehealth originating site payment.

https://data.hrsa.gov/tools/medicare/telehealth

Authorized originating sites* which meet the following criteria shall be designated as eligible for Medicare telehealth payment:

- Analysis indicates that the address does not fall in a metropolitan statistical area **OR**
- If address falls in a metropolitan statistical area, then the address must be in a rural area and be in a Primary Care or Mental Health geographic Health Professional Shortage Area (HPSA).

*Authorized originating sites include:

Offices of a Physician or Practitioner
Hospitals
Critical Access Hospitals
Community Mental Health Centers
Skilled Nursing Facilities
Rural Health Clinics
Federally Qualified Health Centers
Hospital-Based or Critical Access Hospital
Renal Dialysis Facilities
Homes of patients w/ESRD getting home dialysis
Mobile Stroke Units

All data on eligibility for Medicare telehealth payments is updated once each year. The results of the analyzer are consistent across the entire calendar year and will be updated on January 1 of the following year.

A fact sheet on Medicare telehealth services targeted towards Medicare fee-for-service providers is available at: https://www.cms.gov/Outreach-and-Education/Medi care-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

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