Virtual Care in the Teaching Setting

Effective April 21, 2020 at 8 AM
During COVID Emergency Period
For Partners Clinicians in Massachusetts

Collaboration on this document by GME, OGC and Billing Compliance Representatives

What are (1) the requirements for supervision of Residents using Virtual Visits to replace an in person visit and (2) what can be billed for?

(1) Supervision of Residents must continue to be consistent with current requirements but the location of the Attending physician who is supervising the Resident service may be extended to any location where the Attending is immediately available, by Video or Phone. For example, an Attending physician who is in another location, including furloughed at home, may remotely (whether by telephone or virtual visit) supervise a Resident. For details regarding this change during the PHE, please reference the second question on page 2.

(2) If the Attending Physician remotely participates in the care of a patient **synchronously**, by telephone or virtual visit, or provides a personal Virtual Visit at a separate time on the same date of service, the Attending may bill for the service using the correct modifiers (GPH for telephone or GT for virtual visit). Residents should use the "telemedicine encounter" visit type in Epic for on-the-fly services or work off the Cadence schedule, complete fields as they would as if it was an in-person visit and then route the note when signed to the supervisor for attestation (.vvattest), cosign (and for some workflows billing) as per usual in-person routine. Please note that in some programs Residents select the billing codes, and in others they do not. These workflows should not change.

The Attending must participate in the service and be able to intervene, ask additional questions and have a personal communication with the patient in order to bill for services. Workflows will need to be developed and distributed to explain how to coordinate this real-time interaction and are in process now. By phone it will involve conferencing in an Attending supervisor, and by video adding them into the videoconference as a 3rd party. Videoconferencing is preferred over Teleconferencing.

Public Health Emergency (PHS) Changes

Direct Supervision Requirements

- CMS has extended the definition of Direct Supervision to include virtual audio/visual, real-time technology communications

Inpatient Billing for ACGME Residents

- In the non-PHE environment for an ACGME trainee, all inpatient services at the home institution are considered part of the training program and are not separately billable, even if the trainee is fully licensed, appointed, and acting in a moonlighting capacity. During the PHE, inpatient services will be considered separately billable, as long as the other requirements (including licensure, appointment and payer enrollment) are met.

Billing Q&A for Teaching Services During the PHE

What are the payment criteria for a professional service in the teaching setting?

In a teaching setting, for an Attending Physician to be reimbursed for a service, one of the following criteria must be met:

- Service is personally furnished by a physician who is not a resident
- Service is furnished by a resident when a teaching physician is physically present during the critical or key portions of the service
- Service is furnished by a resident under a Primary Care exception within an approved GME program (this is uncommon, but possible)

What flexibilities for "physically present" have been allowed during the COVID Public Health Emergency (PHE)?

In the March 31, 2020 Interim Final Rule, CMS extended the definition of Direct Supervision to include virtual audio/visual real-time communication technology. This means that the Resident may perform a service and the Attending Physician may participate in real-time through audio/visual means. Please note that this extension of the definition does not apply in surgical, high risk, interventional, or other complex procedures, including services rendered through an endoscope, and anesthesia services.

If the Resident is performing a Virtual Video Visit with a patient, and the Attending Physician is participating via Virtual Telephone Visit, should the GT (video) modifier or the GPH (telephone) modifier be used?

The modifier submitted should reflect the service provided by the Attending Physician. Therefore, the GPH modifier should be used in the scenario above. Please note that Video Visit is the currently recommended option, if possible.

If the Resident spends 20 minutes on a Virtual Video Visit with a patient and the Attending Physician attends for an additional 10 minutes, can we only bill for a 10 minute visit?

This is true, if you choose to bill based on time. Only the Attending Physicians personal time is billable. However, you may choose to bill on complexity of the service provided and the complexity may be determined using the Resident's work in combination with the Attending's work.

If the Resident performs a Virtual Visit with a patient in the morning and the Attending doesn't "see" the patient until later in the afternoon, is that ok and can the Attending still bill for his/her personal service?

Yes. If supervision is being provided in a standard of care manner for a Virtual Visit for a patient in the state of MA, and you as the Attending Physician are personally performing a direct service to the patient, you may bill.

I've heard that we can only bill for Virtual Visits by time – is that true?

No, Virtual Visits may be billed based on Attending Physician time, or the complexity of the patient and service provided. However, the current ask is that time is included in all Virtual Telephone Visit services,

because the Revenue Cycle needs this information to bill payers based on their guidelines during the PHE. This does not negate your ability to select an E/M level based on complexity, during the PHE, even when provided through a Virtual Telephone Visit.

Can Residents perform virtual services by Virtual Video or Phone Visit?

Yes, as long as the care being provided is in scope of the individual's practice and license, the patient is located in the state of Massachusetts and appropriate supervision is provided.

Can a Resident provide a Virtual Visit to a patient outside of Massachusetts?
Residents are not authorized to provide a Virtual Visit to a patient outside of Massachusetts unless an Attending Physician is personally (including virtually) present for the entirety of the service being delivered.

Can Residents charge for services independently performed virtually over the phone or video?

No, Residents are not eligible to bill for independently performed services unless they are part of the Medicare Primary Care exception program.

I'm a Resident. How do I close my encounter for billing if my Attending was not present for the telemedicine service?

Select the "No LOS" button in the LOS Section of the Wrap-Up screen and close the encounter.

I am an Attending Physician providing a consult to a Resident while at home, or in another part of the hospital. Can I charge for the services the Resident is providing?

No. If the Attending physician provides asynchronous consultation to the Resident but does not directly participate in care with the patient, s/he may not bill for the service even if s/he participates in the overall medical decision making

I've heard that we should only bill an established Level 3 (99213). Is that true?

This is ONLY true for Residents working in a practice under the Primary Care Exception model. There are very few of these at PHS, so please speak to your Program Director if you are unsure. If you are NOT in a Primary Care Exception practice, the service billed should reflect the service provided.

As a subspecialist seeing patients in a Virtual Visit unrelated to COVID, do we still need to include COVID in the "reason for visit" and as a billing diagnosis?

No, your reason for visit should clearly indicate the reason for which you are virtually seeing the patient, and your diagnosis should reflect your patient's disease accurately. Virtual Visits are allowable for all patients, regardless of their COVID status.

What is the story with "arriving" patients for Virtual Visits?

If your visit is accurately scheduled in Cadence with a Virtual Visit type and your encounter is closed in Epic, your visit will be auto-arrived after 4 days. Please ensure documentation is completed in a timely manner.

Can I provide telemedicine visits for inpatient services?

Yes. If you deliver care through Virtual Video Visit or Virtual Telephone Visit, use the appropriate modifier to reflect your service (please remember your modifier should reflect the Attending's mode of participation, not the Resident mode of participation). This includes Initial, Subsequent, Discharge and Critical Care services. Your service will be billed appropriately based on individual payer rules.

My patient is intubated. Can I still bill for the service I provide to them?

Yes, but please note the following best practices. In this scenario, the recommendation would be to utilize a staff member to assist with a technology device in the patient's room so that you can recreate as much of the patient assessment as possible. It is understood that this is a highly variable situation and feasibility differs for every patient. If you are unable to perform a piece of a medically necessary exam or assessment, please document why (i.e. patient is intubated and unable to participate).

Additional Resources

For Virtual Visit Operations and Implementation questions, please contact your local Telemedicine lead.

For Virtual Visit Charging Workflow and Revenue Cycle questions, please contact Maria Veo and Lynda Brown.

For Virtual Visit Documentation and Coding questions, please contact your local Billing Compliance Director (MGH – Lindsey Reilly).

For legal questions concerning Virtual Care, please contact the Office of General Counsel.