June 24, 2024 | Volume 38, Issue 25

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Billing

Check your telehealth compliance, align POS codes to avoid costly denials

Double check Medicare's telehealth services list before you use a telehealth place of service (POS) code on a claim — or risk an automatic denial. A recent change request from CMS serves as a reminder to make sure you're complying with Medicare's current telehealth requirements.

The COVID-19 public health emergency (PHE) waivers for telehealth services are currently set to expire on Dec. 31, 2024. But effective Jan. 1, 2024, Medicare instructed all providers to report telehealth services with one of the following POS codes based on whether the patient was at home or in another location when they received the telehealth service:

- **02** (Telehealth provided other than in patient's home. The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.)
- **10** (Telehealth provided in patient's home. The location where health services and health related services are provided or received, through telecommunication technology. Patient is located in their home [which is a location other than a hospital or other facility where the patient receives care in a private residence] when receiving health services or health related services through telecommunication technology.)

The 2024-effective guidance was a change from the PHE waiver guideline to report the POS for the setting where the in-person visit would have occurred. For example, practices reported POS **11** (Office) if the in-person visit would have taken place in the medical office.

CMS 100-04, Change Request 13582 reminds providers to use the telehealth POS codes and that POS codes 02 and 10 can only be reported with the 268 designated telehealth services. If you report the POS code for a service that isn't on the list, your Medicare administrative contractor (MAC) will deny your claim with group code (GC) **CO** (Contractual obligation), claim adjustment reason code (CARC) **96** (Non-covered charge[s]) and remittance advice remark code (RARC) **N776** (This service is not a covered Telehealth service). You'll have to start the appeals process if you want to get paid.

Because the new rule directly affects reimbursement, make sure your providers are confirming and documenting the patient's location to prevent improper payments. Your practice will receive the facility rate for services you bill with POS 02 and the higher non-facility rate when you report services with POS 10.

Providers must also document the type of connection they used for the telehealth service. The change request clarifies that you should pair the telehealth code with the modifier that shows the type of telehealth connection. For audio-only encounters, report modifier **93** (Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system). For audio and video encounters, use modifier **95** (Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system).

"Use of audio-only (93) or audio-video (95) does not change rate of payment, only the POS code determines the non-facility or facility payment rate," CMS explains in the change request. — *Julia Kyles, CPC* (*julia.kyles@decisionhealth.com*) ■

RESOURCES

- CMS 100-04, Change Request 13582: *www.cms.gov/files/document/r12671cp.pdf*
- Medicare telehealth list: *www.cms.gov/medicare/coverage/telehealth/list-services* (Zip file)

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ISSN 0893-8121. *pbncustomer@decisionhealth.com* Price: $699/year.