Telehealth and COVID-19

Effective for services starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payments for Medicare telehealth services furnished to patients in broader circumstances. This includes professional services furnished to beneficiaries in all areas of the country in all settings, including patients' homes. These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits. This expanded access to telehealth covers all Medicare beneficiaries, not just those that have novel coronavirus, for the duration of the COVID-19 Public Health Emergency. Below is a summary of commonly asked about topics, including resources.

Eligible services
Only certain codes and services have been deemed eligible for telehealth by CMS. They are listed here and are services CMS has deemed appropriate to be delivered in non-face-to-face settings. More background on CMS coverage of telehealth is available in this Medicare Learning Network booklet.

Qualified providers
The types of providers who can deliver telehealth services are unaffected by recent changes to reimbursement policy. Physicians, nurse practitioners, physician assistants, certified nurse midwives, nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may provide telehealth services within the scope of their practice.

Prior relationships
To the extent the Public Health Emergency waiver requires a patient to have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. See Question 7 of this Frequently Asked Questions (FAQs) document CMS published on March 17.

Licensing
Generally, a provider must be licensed to practice in the state where the patient is located. However, during the public health emergency, CMS says it will temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services to Medicare patients when they are licensed in another state. According to the American Medical Association, many governors have relaxed licensure requirements related to physicians licensed in another state as well as retired or clinically inactive physicians. However, not every state has clearly implemented such waivers of in-state licensure, so the requirements of each state should be evaluated. This interactive map may provide useful information on such issues, and the Federation of State Medical Boards updates each state's policy in this document.

Use of technology platforms to connect with patients
CMS requires telecommunications technology that has audio and video capabilities that are used for two-way, real-time, interactive communication. However, under this Public Health Emergency waiver, HHS is allowing use of smartphones — or "telephones with audio and video capabilities" — to be used to deliver Medicare telehealth services under the COVID-19 Public Health Emergency waiver. In addition, effective immediately, the HHS Office for Civil Rights will waive Health Insurance Portability and Accountability Act (HIPAA) penalties against healthcare providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. HHS recommends that providers inform patients of potential privacy risks of using these forms of communication and enable all of those systems' encryption and privacy modes when in use. More information is available here.

Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
Under the CARES Act that was signed into law on March 27, Congress allowed FQHCs and RHCs the same freedoms to use telehealth in Public Health Emergencies. Like previously, FQHCs and RHCs can also serve as the originating site for telehealth services and bill for virtual check-ins and e-visits.

Non-telehealth services
CMS published a fact sheet on various other ways to use technology to treat patients, including through the use of "Virtual Check-Ins," which are short patient-initiated communications with a healthcare practitioner, and "E-visits," which are non-face-to-face patient-initiated communications through an online patient portal. The below chart is helpful.

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99431 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

Documentation
Documentation requirements for any form of virtual care (telehealth service or non-telehealth digital online service) are the same as those for documenting in-person care. Real-time videos, such as during a video visit, or video phone call are not required to be stored. If a code is time-based, evidence of time must be documented.

Billing
For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) Code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site. Unlike other claims for which Medicare payment is based on a "formal waiver," telehealth claims don't require the "DR" condition code or "CR" modifier. CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. More information is available here.

Cost sharing
In response to the unique circumstances resulting from the outbreak of the COVID-19 public health emergency, the HHS Office of Inspector General will allow healthcare providers to reduce or waive beneficiary cost-sharing for telehealth visits paid for by federal health care programs through a policy statement issued on March 17, 2020. More information is available in two FAQ documents issued here and here.

Medicaid
Telehealth allowances and requirements for Medicaid vary from state to state, and you should check with individual states for what's possible. CMS did release this guidance to assist states in understanding policy options for paying Medicaid providers that use telehealth. CMS is encouraging states to consider telehealth options as a flexibility in combating the COVID-19 pandemic and increasing access to care.

When does this expanded access to telehealth end?
The telehealth waiver will be effective until the public health emergency declared by the Secretary of Health and Human Services (HHS) on January 31, 2020, ends. NAACOS will update members when more information is provided.

NAACOS advocacy
NAACOS has been a long-time supporter of telehealth, advocating for its broader use to help increase access to care and improve inefficiencies in our delivery system. We've asked Congress to expand the use of telehealth to all ACOs, regardless of level of risk or choice of attribution. More recently, NAACOS has asked that Congress to expand definitions of qualified providers during times of public health emergencies. We are pleased to see policy changes to enable greater use of telehealth and will continue to advocate for its expansion and policy changes to support its effectiveness.

Following enactment of the CARES Act, NAACOS is seeking additional clarification and flexibilities from CMS that will further allow ACOs to take advantage of telehealth and remote, virtual care. Those clarifications and flexibilities include, but are not limited to:

- Modifying risk adjustment policies to incorporate diagnoses from telehealth encounters (currently telehealth is not "risk adjustable");

- Seeking clarification on how to deliver annual wellness visits via telehealth;
- Seeking clarification on how telehealth visits will impact beneficiary attribution for ACOs;
- Adjusting the current telehealth payment methodology to pay telehealth claims at a non-facility rate; and
- Having HHS OIG allow remote patient monitoring technologies to be provided to patients under the Anti-Kickback Statute.

Other resources

- CMS Fact Sheet
- CMS FAQs
- CMS General Provider Telehealth and Telemedicine Tool Kit
- HHS FAQs on Telehealth and HIPAA during the COVID-19 nationwide public health emergency
- Alliance for Connected Care Telehealth Guidance Documents During the COVID-19 Pandemic
- Connected Health Initiative's Digital Health Primer for COVID-19
- American Medical Association quick guide to telemedicine in practice
- FDA guidance on providing non-invasive remote monitoring devices

If you have questions, please contact us at advocacy@naacos.com