Telehealth and COVID-19

Effective 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. More background on CMS coverage of telehealth is available in this Medicare Learning Network booklet.

Eligible services

Only certain codes and services have been deemed eligible for telehealth by the Centers for Medicare & Medicaid Services (CMS). They are listed here and are services CMS has deemed appropriate to be delivered in non-face-to-face settings. In an interim final rule published in the Federal Register on April 6, CMS added about 80 additional telehealth-eligible services, including for emergency department visits, initial nursing facility and discharge visits, and home visits. This resource provides more information on the March 30 interim final rule.

Following an interim final rule published in the Federal Register on May 8, CMS will change the way it adds services to Medicare's list of those eligible to be delivered via telehealth. Normally, CMS adds services annually through the Physician Fee Schedule. But since the agency needs to be nimbler adding codes to its list, CMS will instead use sub-regulatory guidance during the COVID-19 public health emergency to add services to Medicare's list of those eligible to be delivered via telehealth. CMS points out that any services added during the pandemic would remain on the list only during the COVID-19 public health emergency.

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.

Under the May 8th interim final rule, CMS expanded the types of practitioners that may bill for telehealth services when furnished from the distant site. This allows health care professionals who were previously ineligible to provide and bill for Medicare telehealth services, including physical therapists, occupational therapists, and speech language pathologists.

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. Under the April 6th interim final rule, CMS will allow clinicians to deliver remote patient monitoring and virtual check-ins to new patients, as well as established patients. More information on the April 6th rule can be found in this CMS fact sheet.

Expansion of Codes used in Beneficiary Assignment
CMS uses more than 60 Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes for MSSP assignment and lists them in §425.400(c)(1)(iv). Of these, 51 appear on CMS's list of services eligible to be delivered through telehealth. NAACOS has heard from some ACOs whose physician practices are now conducting as many as 90 percent of their visits through telehealth. Unless CMS recognizes these telehealth visits for the purposes of patient assignment, these ACOs run the risk of either losing their assigned patient populations or not meeting the minimum 5,000 beneficiary threshold for MSSP.

As a result of NAACOS advocacy, CMS in the May 8 rule says it will count certain services delivered virtually, through telehealth, virtual check-ins, e-visits, or telephone, toward MSSP assignment effective for the 2020 performance year and any other performance year that starts during the COVID-19 public health emergency. This means the primary care services used to develop ACO assignment lists will be used in assignment if delivered through telehealth beginning March 1 and lasting through the public health emergency.

Several codes added to CMS's list of Covered Telehealth Services for the COVID-19 PHE are already included in the definition of primary care services used in MSSP assignment. Those codes are: 99304-99306, 99315-99316, 99327-99328, 99334-99337, 99341-99345, and 99347-99350. In this rule, CMS clarifies that these CPT codes will continue to be included in the definition of primary care services used for assignment, including when they are furnished via telehealth starting March 1 and going forward during the public health emergency. CMS has also clarified for NAACOS that primary care services previously eligible for telehealth were counted toward MSSP assignment whether delivered in-person or via telehealth even before the public health emergency. These include services such as annual wellness visits, outpatient E/M services for new and established patients, transitional care management, advanced care planning, among other services.

Additionally, CMS will use remote evaluation of patient video/images (G2010), virtual check-ins (G2012), e-visits (99421-99423), and newly covered telephone E/M services (99441-99443) for ACO patient attribution for performance year 2020 and for any subsequent performance year that starts during the public health emergency. CMS states in the rule that it believes including these telehealth services in MSSP beneficiary assignment would result in a more accurate reflection of where patients receive a plurality of their primary care.

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. The Federation of State Medical Boards updates each state's policy in this document.

Use of technology platforms to connect with patients
CMS usually requires telecommunications technology that has audio and video capabilities that are used for two-way, real-time, interactive communication. However, under the Public Health Emergency, and as a result of NAACOS advocacy, CMS said it would waive its video requirement for certain telehealth services, allowing them to be delivered through audio-only telephone calls. NAACOS heard from members that many Medicare beneficiaries do not have access to the interactive, audio-video technology Medicare typically requires for telehealth. In order to increase access to care for these beneficiaries, CMS granted a blanket waiver pursuant to authority granted to it under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. On the downloadable file listing all of Medicare's telehealth-eligible services, CMS created a new column that states if a services can meet the new audio-only requirements. Eighty-nine of the 238 services listed are eligible for audio-only.

Also during the public health emergency, the U.S. Department of Health & Human Services (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, 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.

Payment for Audio-Only Telephone Evaluation and Management Services
In April 6th internal final rule, CMS began reimbursing CPT codes 98966-98968 and 99441-99443, which cover prolonged, audio-only communication between the practitioner and the patient. These were previously uncovered and can be delivered to new or established patients. This would allow clinicians to communicate with patients through simple telephone calls if patients were unable to access video for visits. NAACOS and other stakeholders noted how low the reimbursement was for these services.

As a result of advocacy, CMS in the May 8th internal final rule said it would more than double the reimbursement for CPT codes 99441-99443. Specifically, CMS is cross-walking CPT codes 99212-99214, which are the most analogous office/outpatient Evaluation and Management (E/M) codes, to 99441-99443. The RVUs for the duration of the COVID-19 public health emergency will be 0.48 for CPT code 99441; 0.97 for CPT code 99442; and 1.50 for CPT code 99443. This would increase payments for these services from a range of about $14-$41 to about $46-$110. The payments are retroactive to March 1, 2020. CMS is not increasing payment rates for CPT codes 98966-98968 since these are furnished by practitioners who cannot independently bill for E/M services, and so these telephone services, by definition, are not furnished in lieu of an office/outpatient E/M service.

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. This includes serving as distant site providers. This HRSA document provides more information. Like previously, FQHCs and RHCs can also serve as the originating site for telehealth services and bill for virtual check-ins and e-visits.

On April 17, CMS published guidance on how it will pay FQHCs and RHCs for telehealth services during the public health emergency. For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, RHCs will be paid at their all-inclusive rate, and FQHCs will be paid based on their Prospective Payment System rate. These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. FQHCs and RHCs must use the 95 modifier and used real-time, interactive video on claims. For telehealth distant site services furnished between July 1, 2020, and the end of the public health emergency, RHCs and FQHCs will use an RHC/FQHC specific G code, G2025, to identify services that were furnished via telehealth. RHC and FQHC claims with the new G code will be paid at the $92 rate, which is the average amount for all of CMS's telehealth-approved services, weighted by volume.

Risk Adjustment

In an April 10 memo, CMS instructed Medicare Advantage (MA) organizations and other organizations "to submit diagnoses for risk adjustment that are from telehealth visits when those visits meet all criteria for risk adjustment eligibility." Risk scores for telehealth can only be submitted for services delivered using two-way, interactive video. Submissions apply to the Risk Adjustment Processing System (RAPS). CMS explains in this FAQ that "e-visits" will be eligible for risk adjustment. NAACOS has asked that CMS recognize diagnoses obtained from audio-only telehealth services for risk adjustment purposes.

Annual Wellness Visits (AWVs)

The delivery of AWVs is one of the most asked about issues NAACOS fields around telehealth. When AWVs were added to the list of telehealth-eligible services, originating sites were other hospitals and clinics, and CMS didn't envision them being conducted in patients' homes. Therefore, CMS has to clarify how certain elements of AWVs, such as the collection of blood pressure and weight, can be documented via telehealth. NAACOS has asked CMS to allow flexibility in AWVs for those elements that do require a clinician's touch. We will alert members when CMS issues more guidance.

While we await a formal written confirmation from CMS in the form of sub-regulatory guidance such as a memo or FAQ, agency staff verbally explained on a May 12 CMS Office Hours call that patient-reported vital signs are acceptable for AWVs furnished via telehealth. CMS is still considering how to address visits when the patient cannot self-report. NAACOS will update this resource when additional information becomes available.

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

In the April 6th interim final rule, CMS said it would begin paying for telehealth services at a "non-facility rate," which yields a higher reimbursement for clinicians. The non-facility rate is the amount paid to a clinician for services delivered in their office. The facility rate is the amount generally paid to a professional when a service is furnished in a care setting, such as a hospital, where Medicare is making a separate payment, often called the "facility fee," to an entity in addition to the payment to the billing physician or practitioner. This payment differential was resulting in lower reimbursement for telehealth services.

CMS instructs clinicians who bill for Medicare telehealth services to report the place-of-service (POS) code that would have been reported had the service been furnished in-person. Additionally, CMS finalized on an interim basis the use of the CPT telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth. Unlike previously, claims should not include the POS code "02-Telehealth," as CMS will continue to reimburse those services at the lower facility rate. 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. More information is available here.

Payment for Remote Physiologic Monitoring Services

Through CPT codes 99091, 99453, 99454, 99457, and 99458, CMS in recent years has moved to pay for remote patient monitoring, which allows clinicians to be reimbursed for the collection and reading of patients' physiologic data, such as weight, blood pressure, pulse oximetry, and respiratory flow rate, through digital technologies. But Medicare only pays for these services if data is collected for at least 16 days out of a 30-day period.

For the duration of the COVID-19 public health emergency, CMS will pay for remote patient monitoring for as short as two days, as long as all other requirements for billing the code are met. The agency states it is making this change because many COVID-19 patients don't need as many as 16 days of remote monitoring. CMS will not alter the payment for remote monitoring CPT codes 99454, 99453, 99091, 99457, and 99458. This change is limited to patients who have a suspected or confirmed diagnosis of COVID-19.

Other forms of telehealth services

CMS published a fact sheet on March 17 on the 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. Under the March 30 internal final rule, clinicians can now provide virtual check-ins to both new and established patients.

Also under the April 6th rule, clinicians can provide remote patient monitoring services for patients, no matter if it is for the COVID-19 disease or a chronic condition. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. The below chart might be helpful.

Type of Service	What is the Service?	HCPCS/CPT Code
Medicare Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and a patient.	For a complete list, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Virtual Check-in	A brief (5-10 minute) 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 a patient.	G2010 G2012

E-Visit	A communication between a patient and their provider through an online patient portal.	99421-99423 G2061-G2063

Hospitals Without Walls
Telehealth is typically limited to billable professional services, as hospitals were limited to providing services to patients within their own buildings. However, during the public health emergency, CMS is allowing healthcare systems and hospitals to provide services, including telehealth, in locations beyond their existing walls. Through a temporary expansion of its Hospitals Without Walls initiative, CMS is waiving the provisions related to telemedicine for hospitals and critical access hospitals, making it easier for telemedicine services to be furnished to the hospital's patients through an agreement with an off-site hospital. This allows for increased access to necessary care for hospital patients, including access to specialty care.

For the duration of the public health emergency, hospitals may bill the originating site facility fee for telehealth services when a patient is receiving a telehealth service in a temporary expansion location that is a provider-based department of the hospital and the patient is a registered outpatient of the hospital. Furthermore, hospitals may bill for telehealth services provided by hospital-based clinicians to registered outpatients, including when the patient is at home.

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, remote patient monitoring, and broader categories of non-face-to-face services 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 released this guidance and an FAQ document to assist states in understanding policy options for paying Medicaid providers that use telehealth. An April 2 bulletin provided more detail on treating patients with substance use disorder. 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.

Federal Communications Commission (FCC)
On April 13, the FCC began accepting applications for its COVID-19 Telehealth Program. This will provide $200 million to help healthcare providers offer telehealth services and devices during the ongoing pandemic. Eligibility is limited to public and nonprofit healthcare providers. ACOs are eligible to apply as a consortium if all their participating providers are also eligible. NAACOS has asked the FCC to expand eligibility to for-profit providers, which would include hospitals and medical practices.

Another program, called the Connected Care Pilot Program, would make $100 million available for providers to offer telehealth services to patients located at home or anywhere outside of a healthcare facility. More information are here and here.

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 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 sought additional clarification and flexibilities from CMS that will further allow ACOs to take advantage of telehealth and remote, virtual care. CMS has responded to some, but not all of our requests. Those clarifications included:

- Clarifying how to deliver annual wellness visits via telehealth;
- Clarifying how telehealth visits will impact beneficiary attribution for ACOs;
- Seeking wider use of "telephone-only" visits, which might be allowable under Section 3703 of the CARES Act;
- Modifying risk adjustment policies to incorporate diagnoses from telehealth encounters;
- Having the HHS Inspector General allow remote patient monitoring technologies to be provided to patients under the Anti-Kickback Statute; and
- Making FQHCs' and RHCs' payment for telehealth services retroactive to March 27.

NAACOS continues to seek answers from CMS and advocate for ACOs on issues of importance around telehealth.

Other resources

- HHS Overview on Telehealth
- CMS Fact Sheet (published March 17)
- CMS Telehealth Frequently Asked Questions (FAQs) (updated March 17)
- CMS General Provider Telehealth and Telemedicine Tool Kit
- CMS memo on risk adjusting telehealth services (published April 10)
- CMS guidance on physicians and other clinicians' flexibilities to fight COVID-19 (published March 30)
- CMS "Dear Clinician" letter of COVID-19 (updated April 7)
- CMS FAQs on Medicare Fee-for-Service Billing
- COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers
- CMS State Medicaid and CHIP Telehealth Toolkit
- CMS Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit
- CMS FAQs on Availability and Usage of Telehealth Services through Private Health Insurance Coverage in Response to COVID-19 (updated March 24)
- 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 (published March 20)

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