Next Generation ACO Model
Telehealth Expansion Waiver Frequently Asked Questions

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Currently, in traditional fee-for-service Medicare, use of the telehealth benefit is limited to rural Health Professional Shortage Areas (HPSA[1]), CMS defined telehealth originating sites, and synchronous telehealth services. The Next Generation ACO Telehealth Expansion Wavier eliminates the rural geographic component of originating site requirements, allows the originating site to include a beneficiary's home, and for the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology. The waiver will apply only to beneficiaries aligned to a Next Generation ACO and for services furnished by a Next Generation Participant or Preferred Provider approved to use the waiver.

An aligned beneficiary will be eligible for the Telehealth Expansion Waiver if the beneficiary is located at their home or one of the Centers for Medicare & Medicaid Services (CMS) defined telehealth originating sites.

This document provides frequently asked questions and answers related to the Telehealth Expansion Waiver. The first section includes questions around waiver policy, and the second section describes questions around data submission requirements.

Telehealth Waiver Policy Questions

Q1: **What telehealth services are covered by Medicare?**

A: Medicare currently covers a limited number of Part B services delivered by an approved provider to a Medicare beneficiary. The beneficiary must be located in an approved "originating site" and services must be delivered by face-to-face consult using live video conferencing technology.

Q2: **What is an originating site under existing Medicare telehealth rules?**

A: An originating site is the place where the patient is located when the telehealth service is provided. Approved originating sites include the following:

- Physicians' or practitioners' offices
- Hospitals
- Clinics and federally qualified health centers
- Hospital-based renal dialysis centers (including satellites)[2]
- Skilled nursing facilities (SNFs)
- Community mental health centers

Q3: **Who can bill for providing telehealth services?**

A: Only the following providers can receive reimbursement for delivering care using telehealth technology:

Physicians	Clinical nurse specialists (CNSs)
Nurse practitioners (NPs)	Certified registered nurse anesthetists
Physician assistants (PAs)	Clinical psychologists
Nurse midwives	Clinical social workers
Registered dieticians	Nutrition professionals

[1] For information on HPSAs, visit https://bhw.hrsa.gov/shortage-designation/hpsas.
[2] Independent renal dialysis facilities do not qualify as originating sites.

Q4: **What billable services can be provided using synchronous telehealth technology <u>at an originating site that is not a beneficiary's home</u>?**

A: The existing telehealth HCFA (Healthcare Financing Administration) Common Procedure Coding System [HCPCS]/Current Procedural Terminology [CPT] codes[3] delivered via synchronous telehealth are reimbursable by Medicare for the Next Generation ACO Model Telehealth Expansion Waiver as long as services are delivered by an approved provider to a patient located at an approved originating site (that is not a beneficiary's home).[4]

Q5: **What billable services can be provided using synchronous telehealth technology <u>at a beneficiary's home or place of residence</u>?**

A: The following services (and HCPCS/CPT codes) delivered via synchronous telehealth are reimbursable by Medicare as long as they are delivered by an approved provider.

<u>HCPCS Code Numbers: G9481 – G9485</u>

- **Long Descriptor**: Remote in-home visit for the evaluation and management of a *new* patient for use only in the Medicare-approved CMMI model, which requires these 3 key components:
    - A problem focused history;
    - A problem focused examination; and
    - Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, time is spent with the patient or family or both via real time, audio and video intercommunications technology
- **Short Descriptors**:

G9481: Remote E/M new pt 10 mins.	G9484: Remote E/M new pt 45 mins.
G9482: Remote E/M new pt 20 mins.	G9485: Remove E/M new pt 60 mins.
G9483: Remote E/M new pt 30 mins.	

<u>HCPCS Code Number: G9486 – G9489</u>

- **Long Descriptor**: Remote in-home visit for the evaluation and management of an *established* patient for use only in the Medicare-approved CMMI model, which requires at least 2 of the following 3 key components:
    - A problem focused history;
    - A problem focused examination;
    - Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, time is spent with the patient or family or both via real time, audio and video intercommunications technology.
- **Short Descriptors**:

G9486: Remote E/M est pt 10 mins.	G9488: Remote E/M est pt 25 mins.
G9487: Remote E/M est pt 15 mins.	G9489: Remote E/M est pt 40 mins.

- Work and MP RVUs equal to those of the corresponding office/outpatient Evaluation and Management (E/M) visit CPT Codes: 99201 - 99215

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[3] CPT (Current Procedural Terminology) Copyright Notice
Throughout this FAQ, we use CPT codes and descriptions to refer to a variety of services. We note that CPT codes and descriptions are copyright 2016 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.
[4] The complete list of services, with descriptions, is available here: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

Q6: **Can an Annual Wellness Visit be provided to a beneficiary in their home using telehealth?**

A: No. While the Annual Wellness Visit can be provided using synchronous telehealth, it cannot be provided if the beneficiary's home is the originating site. Since specific HCPCS codes (G0438 and G0439) are necessary to bill for the Annual Wellness Visit provided through telehealth and those codes do not allow a beneficiary's home as an originating site, and specific HCHCS codes (G9481 - G9489) are required to use the Next Generation Telehealth Expansion Benefit Enhancement when the beneficiary's home is the originating site, the Annual Wellness Visit cannot be provided in a beneficiary's home.

Q7: **Can an Annual Wellness Visit be provided using telehealth in a non-HPSA (i.e., non-rural or urban) area?**

A: Yes. A provider can use the existing HCPCS codes (G0438 and G0439) to bill the Annual Wellness Visit when the services were given in a non-HPSA (i.e., non-rural or urban) area.

Q8: **How does this waiver differ from what is currently covered by Medicare?**

A: This waiver does not expand the list of covered services. The waiver extends the use of telehealth services in two distinct ways: (1) the originating site (where the patient is located at the time of service) does not have to be in a rural HPSA area; and (2) the list of approved originating sites has been expanded to include the patient's place of residence (that is, home).

Q9: **How do I bill telehealth waiver services?**

A: Telehealth service providers should follow the Medicare fee-for-service rules by using the appropriate Place of Service (POS) and HCPCS or CPT code to indicate the professional service was delivered using synchronous (that is, real-time) technology. For further detail regarding reporting telehealth services, see the Medicare Claims Processing Manual, Pub. 100-04, chapter 12, section 190.3, available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf.

Q10: **Which POS code should be used when the originating site is the beneficiary's home?**

A: POS 02 (telehealth) should be used for most synchronous telehealth services reported by physicians or practitioners (that is, the distant site provider). More information about this guidance is available in the 2018 Physician Fee Schedule (https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf). POS 12 (beneficiary's home) should be used when the beneficiary's place of residence was the originating site (applicable to billing codes G9481 – G9489).

Q11: **What is asynchronous telehealth?**

A: Asynchronous telehealth technology is also known as store-and-forward technology. Distinct from synchronous telehealth services (also known as live, real-time, or face-to-face), asynchronous synchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or treatment plan.

Q12: **Are asynchronous telehealth services covered under this waiver?**

A: Yes. Secure Payment will be permitted for asynchronous telehealth in single or multimedia formats that is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these new services using new codes. The distant site practitioner must be a Next Generation Participant or Preferred Provider with the telehealth benefit enhancement selected in the Provider List Submission Tool.

Code	Description	Time	RVU	Reimbursement
G9868	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes	15 minutes	0.8	$28.00
G9869	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes	20 minutes	1.07	$37.45
G9870	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes	25 minutes	1.34	$46.90

Q13: **What is secure messaging and is this covered under the ACO telehealth waiver?**

A: Secure messaging is the use of a secure email server to electronically communicate directly with the patient. Secure messaging is not reimbursed by Medicare because it is considered an alternative to telephone calls between the patient and provider. However, this does not prohibit providers from using secure messaging if it is viewed as a more efficient means for communication.

Q14: **If the ACO intends to use telehealth to support care coordination, are providers able to bill for these services?**

A: Yes, telehealth can be used to support care coordination, as long as services fall under one of the approved service codes and telehealth is used in accordance with current Medicare telehealth coverage rules and the Next Generation Model waiver. To use the waiver, Next Generation participants and preferred providers must be designated on the applicable list with the telehealth benefit enhancement indicator and must be a type of Medicare-enrolled provider that can bill for the codes listed above.

Q15: **Can facilities located in urban areas (that is, non-health professional shortage areas [non-HPSAs[1]] that are serving as an originating site (that is, where the beneficiary is located) bill Medicare for the facility fee payment?**

A: Yes. Facilities located in urban areas (that is, non-HPSAs[1]) that are serving as an originating site (where the beneficiary is located) can bill Medicare for the facility fee payment. ACOs that would like to add facilities for this purpose will indicate the Telehealth Expansion Benefit Enhancement for both physicians and facilities in the Provider List Processing Tool in order to allow physicians (and other professionals) to serve as the distant site practitioner and facilities to serve as the originating site.

Quarterly Data Submission Questions

Q16: **What are the data submission requirements for ACOs participating in the waiver?**

A: Beginning in the second quarter of 2018, ACOs may voluntarily report data on all telehealth services delivered under the waiver. Previously, data submission was mandatory. ACOs may submit data quarterly for the most recent reference period; the Microsoft Excel-based data submission tool provided by the Learning System will note the reference period for a given submission. The most recent data submission tool, which covers 2018 Q2 telehealth waiver services, is available for download on the NGACO Connect website at https://app.innovation.cms.gov/NGACOConnect/069t0000001uRZO. Users must be logged into the NGACO Connect site before using the link.

Q17: **How will the Learning System use the telehealth waiver data submitted by the ACOs?**

A: The Learning System will link submitted data to the corresponding claims record and provide ACOs with information about telehealth waiver service use within their ACOs and across the broader NGACO population.

Q18: **Which telehealth services should be included in the Excel-based data submission tool?**

A: Data can be submitted for all telehealth services that are payable under the waiver. Specifically, services should meet the following criteria:

- Provided to beneficiaries in their home
- Provided to beneficiaries living in urban areas

Beneficiaries may receive more than one telehealth service during the reference period. Each telehealth service the beneficiary receives can be listed in the data submission tool. Do not list any telehealth services that did not require the telehealth waiver (that is, telehealth services delivered in rural or HPSA areas).

Q19: **What data should each telehealth waiver service include?**

A: For each telehealth waiver service ACOs choose to include, ACOs should provide the following data:

- Date of service
- Beneficiary identifier (Social Security number or health insurance claim number)
- Beneficiary date of birth
- Beneficiary gender
- Location of beneficiary at time of service (for example, home, office)
- POS zip code
- Distant provider National Provider Identifier (NPI)
- Originating site NPI (if POS is not the home)

Q20: **How do I make sure that the data I'm submitting are formatted correctly?**

A: Refer to the instructions tab of the data submission tool for information on how to populate each field. After you have populated the template with your data, click the "Validate Data" button at the top of the tab. Any cells that are either formatted incorrectly or incomplete will be shaded in red. Revise all shaded cells and click the "Validate Data" button to see if the shading disappears. When all errors are addressed, the "Validate Data" button will clear all shading from the template.

Q21: **How should I submit the telehealth services data?**

A: Next Generation ACOs should email NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements") to submit data. **Before submission, these data must be encrypted, because they include personally identifiable information.** The password must not be emailed. Instead, the password must be provided to the ACO Information Center by telephone (1-888-734-6433). For more information on the data submission process, see the instructions tab of the data submission tool. As with the data submission tool, users must be logged into NGACO Connect to access the webinar transcript and slides.

Q22: **Where can I find materials related to the telehealth waiver, such as chartbooks, webinar recordings, and data collection tools?**

A: Materials are available on the NGACO Connect site (https://app.innovation.cms.gov/NGACOConnect/CommunityLogin). After logging into the site, you may use the following addresses to access materials relevant to the telehealth waiver:

- Data collection tool for 2018 Q2: https://app.innovation.cms.gov/NGACOConnect/069t0000001uRZO
- Past telehealth waiver affinity group materials: https://app.innovation.cms.gov/NGACOConnect/069t00000012R6Y
- Telehealth user group: https://app.innovation.cms.gov/NGACOConnect/_ui/core/chatter/groups/GroupProfilePage?g=0F9t0000000TNrB

Q23: **How do I get access to the Connect site?**

A: The Next Generation ACO Connect site is equipped with self-registration functionality. Please follow the steps below to access the Connect site, and contact the Center for Medicare & Medicaid Innovation (CMMI) help desk with any questions (CMMIConnectHelpDesk@cms.hhs.gov, subject line "Connect Site"):

- Go to the NGACO Connect log-in page.
- Select "Click Here" next to "New User."
- Fill out your contact and organization information.
- CMMI will review your request and send an email with your log-in information, alerting you to sign in to Connect within six months to activate your account.

Q24: **Who should I contact with questions about the measures and data submission?**

A: Next Generation ACOs should email NextGenerationACOModel@cms.hhs.gov (subject line "Benefit Enhancements"). We look forward to assisting you with any questions, and we welcome suggestions for improving the tool for future rounds of data collection.
