COVID-19 and Virtual Health - April 3 1104

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The below Virtual Health resource was developed by the National Association of ACOs

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 the Centers for Medicare & Medicaid Services (CMS) has deemed appropriate to be delivered in non-face-to-face settings. In an interim final rule published on March 30, CMS added about 80 additional telehealth-eligible services, including for emergency department visits, initial nursing facility and discharge visits, and home visits. 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. Under the March 30 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 March 30 rule can be found in this CMS fact sheet.

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, 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.

Through the March 30 internal final rule, CMS will reimburse CPT codes 98966-98968 and 99441-99443, which pay for prolonged, audio-only communication between the practitioner and the patient. These services were previously not covered but will be covered and paid during the COVID Public Health Emergency. These can be delivered to new or established patients. CMS is also allowing audio-only visits during the public health emergency for the therapy and counseling portions of the weekly bundles, as well as the add-on code for additional counseling or therapy.

98966: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. Work RVU of 0.25

98967: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. Work RVU of 0.50

98968: Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. Work RVU of 0.75

99441: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. Work RVU of 0.25

99442: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous

7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion. Work RVU of 0.50

99443: Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion. Work RVU of 0.75

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.

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 March 30 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 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.

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 March 30 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

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 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.

Federal Communications Commission (FCC)
The FCC has taken steps to establish separate programs that would help healthcare organizations adopt broadband capabilities. Congress appropriated $200 million to help providers purchase telecommunications, broadband connectivity, and devices necessary for providing telehealth services. 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.

Other resources
- CMS Fact Sheet (published March 17)

- CMS FAQs (updated March 17)
- CMS General Provider Telehealth and Telemedicine Tool Kit
- CMS guidance on physicians and other clinicians' flexibilities to fight COVID-19 (published March 30)
- 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)