COVID-19: IMPACT ON MEDICARE TELEHEALTH SERVICES

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U.S. Health Care Alert

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On March 6, 2020, Congress passed the Coronavirus Preparedness and Response Supplemental Appropriations Act (the "Act") which allows physicians and other health care professionals to bill Medicare for patients covered under the traditional fee-for-service Medicare program when care is delivered during the current coronavirus public health emergency ("COVID-19 Emergency") using technology that has real time two way audio and video capabilities. In addition, pursuant to Section 1135 of the Social Security Act, the Secretary ("Secretary") of the U.S. Department of Health and Human Services ("HHS") has broadened the circumstances under which Medicare will pay for telehealth services. Like the Act, the purpose of the waiver is to increase accessibility of eligible telehealth services to Medicare participants in light of the COVID-19 Emergency. [1] Such 1135 waiver authority can be made available only upon both the President's declaration of a national emergency and the Secretary's declaration of a public health emergency. The President's declaration was issued on March 13, 2020, and a declaration by the Secretary of a public health emergency was issued on January 27, 2020.

In addition, in connection with the Act's passage, HHS has exercised its authority to expand access under Medicare for virtual services which would not have met the prior coverage conditions for telehealth. On March 17, 2020, CMS released guidance through a Medicare Telemedicine Health Care Provider Fact Sheet ("Telehealth Fact Sheet") as well as a Medicare Telehealth Frequently Asked Questions ("Telehealth FAQ") (Collectively "COVID-19 Telehealth Guidance").

As used in this alert, "virtual services" is an umbrella term that describes medical interactions between a patient and a provider through an electronic communication in order to improve a patient's health.

Medicare covers four types of virtual services: telehealth visits, virtual check-ins, e-visits and remote assessments of images and videos provided by patients.

- Telehealth visits are defined by Medicare as two-way telecommunications using interactive audio and video that permit real time communication between medical providers and patients.
- Virtual check-ins are brief communications (5-10 minutes) through technology-based applications that allow patients to check-in and communicate with a medical provider.
- E-visits are non-face-to-face patient-initiated communications between patients and their medical providers using online patient portals.
- Remote Assessments of Images are professional evaluations of patient provided images or videos

CMS's most recent guidance addresses each of these categories of virtual services.

I. TELEHEALTH

A. Changes to the Prior Guidelines for Telehealth

In order to respond to the COVID-19 Emergency, the COVID-19 Telehealth Guidance suspended some of the traditional rules for reimbursement of telehealth services by Medicare.

1. The List of Telehealth Services Was Not Changed

While there is no consistent definition of virtual services, the references to telehealth in this alert refer to the federal Medicare definition established by the Social Security Act, which includes the following elements:

1. Only certain listed services,
2. Provided in specific settings, and
3. Provided by specific providers.

The Act did not change the services that can be billed to Medicare as a telehealth service. Common services reimbursable under Medicare 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 Skilled Nursing Facilities). [2]

However, under the COVID-19 Telehealth Guidance, there are changes to the allowable locations for patients, the allowable technology that can be used, and allowable waivers of cost-sharing payments.

2. Changes to What Constitutes an Originating Site

Historically, covered Medicare telehealth services were limited to care provided for a patient at an “originating site.” Other than specific exceptions for Alaska and Hawaii demonstration projects, the patient at the originating site was required to interface in real-time with a provider at a “remote site.”

Under prior Medicare guidelines, originating sites typically could not include a patient's home. Rather, originating sites for telehealth services were limited to sites in either: (i) a county outside of metropolitan statistical areas or (ii) a rural health professional shortage area in a rural census track. In both instances, the originating site had to be a specific eligible site, such as a physician or practitioner's office, a hospital, a skilled nursing facility or a renal dialysis facility. The home of the beneficiary only qualified as an originating site in a handful of instances, such as the home of beneficiaries with end stage renal disease who are getting home dialysis or the home of a patient receiving treatment for Substance Use Disorder/Opioid Abuse and co-occurring mental health disorders. [3]

However, under the COVID-19 Telehealth Guidance, starting March 6, 2020 and for the duration of the COVID-19 Emergency, Medicare will make payment for telehealth services furnished to beneficiaries in any setting anywhere in the United States. This includes services provided to a patient while the patient is at home.

3. Billing and Coding for Telehealth Services Is Changed

Under prior guidance, wherein the originating site for telehealth services was limited, the Medicare enrolled

originating site was permitted to bill Medicare a facility fee using code Q3014. Under both prior and new guidance, if the originating site is at the beneficiary's home, no originating site facility fee can be billed.

Certain modifiers are used to provide additional information to payers to facilitate correct payment. For instance, for Medicare, G0 (zero) is used to identify telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke; GQ is used for asynchronous telehealth service; GT is used by Critical Access Hospital ("CAH") distant site providers billing under CAH Optional Method II; GY is used to report an Advanced Beneficiary Notice that was not issued because an item or service is statutorily excluded or does not meet definition of any Medicare benefit. [4]

The Medicare coinsurance and deductible would generally apply to these telehealth services. However, during the emergency, the HHS Office of Inspector General (OIG) is now providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. [5]

4. Expansion of Eligible Providers

Telehealth services still can only be provided by certain eligible practitioners, such as physicians, nurse practitioners, physician's assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dieticians or nutritional professionals, and opioid treatment programs.

However, CMS has temporarily waived previous Medicare and Medicaid requirements that out-of-state providers hold licenses in the state where they are providing services. This requirement is waived for the duration of the 1135 Waiver as long as the Provider has an equivalent license from another state. It is important, however, to keep in mind that the CMS waiver does not waive state or local licensure requirements. Additionally, the waiver does not allow for payment for otherwise non-covered services.

5. Technology Requirements

When providing telehealth visits, a provider must use an interactive audio and video telecommunications system that permits two way real-time communication between the provider and the patient. During the waiver period, providers are allowed to use everyday communications technologies, such as mobile computing devices, which have both audio and video capability to provide telehealth services. CMS issued a News Release that specifically includes smartphones as appropriate technology. CMS News Release - President Trump Expands Telehealth Benefits for Medicare Beneficiaries During Covid-19 Outbreak Additionally, on March 17, 2020, the Office for Civil Rights ("OCR") announced that it will waive penalties for HIPAA violations by health care providers serving patients during the COVID-19 Emergency who in good faith communicate through common, non-public facing communications technologies, such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype.

6. Coverage for New and Established Patients

As passed, the Act specified that only providers who themselves or through their practice had furnished the patient with an item or service paid by Medicare in the three years prior to the telehealth service were qualified to

bill Medicare covered telehealth services. However, the Act specifically gave the Secretary of HHS the authority to amend certain requirements by program instruction.

The COVID-19 Telehealth Guidance specifically provides that, to the extent the Act "requires that the patient 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." Thus, HHS is not enforcing the three (3) year patient relationship requirement, which would otherwise apply to telehealth providers under the Act.

II. VIRTUAL CHECK-INS AND REMOTE ASSESSMENTS OF IMAGES

Medicare will also continue to pay for virtual check-ins and remote assessments of images in the same manner as under prior guidance. Virtual check-ins are brief communications between providers and patients using technology-based modalities. Remote Assessments of Images are professional evaluations of patient provided images or videos.

Virtual check-ins are covered by Medicare for patients with an established or existing relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous seven days and which do not lead to a medical visit within the next 24 hours (or the soonest appointment available). In these instances, medical provider may bill for these "virtual check-in" services furnished to patients through several communication technology modules, such as telephone (HCPCS code G2012). The service cannot originate from a related E/M service provided within the previous seven days.

Virtual check-ins are not limited to patients in rural settings. Additionally, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication, they can be conducted with a broader range of communication methods. On the other hand, CMS has not extended the enforcement discretion regarding a pre-existing patient relationship to virtual check-ins.

Remote assessments entail a professional evaluation of patient-transmitted videos or images.. Such assessments can be done through asynchronous (or store and forward) technology. Telemedicine Patient follow up is required. Remote assessments are covered by Medicare if the service did not originate from a related E/M service provided within the previous seven days, and which does not lead to an E/M service or procedure within the next 24 hours, or soonest available appointment. Remote assessments are billed with HCPCS code G2010. As with virtual check-ins, HHS has not extended the enforcement discretion regarding a pre-existing patient relationship to Remote Assessments of Images.

III. E-VISITS

Medicare will also continue to pay for e-visits in the same manner as under prior guidance E-visits are covered by Medicare for established patients who initiate non face-to-face communications with their practitioner through the use of online patient portals. Like the "virtual check-ins", these may only be submitted for payment by Medicare where the patient has an established relationship with the medical practitioner. Additionally, the patient must generate the initial inquiry and communications can occur over a seven-day period. The services must be billed by the medical practitioner using Current Procedural Terminology ("CPT") codes 99421-99423, or HCPCS codes G2061-G2063, as applicable. Medicare coinsurance and deductibles will apply to all e-visits.

Conclusion

Although virtual medical services have received extensive focus following passage of the Act and the 1135 Waiver, it is important for providers to understand how to take advantage of all tools available to them under federal health care programs to provide continuity of care for their patients. Utilizing virtual check-ins, remote assessments, and e-visits, in addition to providing telehealth services, provides a myriad of options for patients, while still ensuring that claims will still be reimbursed by Medicare.

Click here for a chart summarizing the coverage rules.

DEFINITIONS:

A. Originating Site is where the patient is located, and that location must meet both the permitted location requirement and the permitted facility requirement, defined below:

> **Permitted locations** are (i) a county outside of metropolitan statistical areas, or (ii) a rural health professional shortage area in a rural census track. **Permitted facilities** are either physician or practitioner offices, hospitals, critical access hospitals, rural health clinics, hospital- and CAH-based renal dialysis centers (including satellites), skilled nursing facilities, renal dialysis facilities, homes of beneficiaries with end-stage-renal-disease-("**ESRD**") -receiving home dialysis, ESRD facilities, Community Mental Health Centers, Federally Qualified Health Centers, or mobile stroke units.

In addition, the home of the beneficiary can qualify as an Originating Site only in a handful of instances, such as the home of beneficiaries with ESRD receiving home dialysis or the home of a patient receiving treatment for substance use disorder/opioid abuse and co-occurring mental-health disorders.

B. Remote Site is sometimes referred to as the "distant site," and this is the location where the practitioner is located.

C. Provider means (subject to state law) physicians, nurse practitioners, physician assistants, nurse-midwives, certified nurse anesthetists, clinical psychologists ("**CPs**"), clinical social workers ("**CSWs**"), registered dietitians, and nutrition professionals. (Note: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for CPT codes 90792, 90833, 90836, and 90838.)

NOTES:

[1] *See* Secretary Alex M. Azar II, *Waiver or Modification of Requirements Under Section 1135 of the Social Security Act (Mar. 13, 2020), https://www.phe.gov/emergency/news/healthactions/section1135/Pages/covid19-13March20.aspx* ("**1135 Waiver**")

[2] *See* Centers for Medicare & Medicaid Services, *List of Telehealth Services*, https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes (last visited Mar. 20, 2020).

[3] *See* Centers for Medicare and Medicaid Services, *MLN Booklet: Telehealth Services* (Jan. 2019)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.

[4] *See* Noridian Healthcare Solutions, *Modifiers,* https://med.noridianmedicare.com/web/jeb/topics/telehealth (last visited March 20, 2020); The National Telehealth Policy Resource Center, Center for Connected Health Policy, *Billing for Telehealth Encounters, An Introductory Guide on Fee-for-Service* (Jan. 2020) https://www.cchpca.org/sites/default/files/2020-01/Billing%20Guide%20for%20Telehealth%20Encounters_FINAL.pdf.

[5] *See* Center for Medicare and Medicaid Services, *COVID-19 Emergency Declaration Health Care Providers Fact Sheet*, https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf (last visited March 20, 2020).

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