Telehealth & Delivering Virtual Services for COVID-19

Frequently Asked Questions (v4)

MediRevv

Updated as of June 9, 2020

Frequently Asked Questions

MediRevv

Telehealth and Delivering Virtual Services for COVID-19

Frequently Asked Questions

This document is designed to assist in providing answers to many of the common Telehealth questions arising from the changing environment in Healthcare operations, due to COVID-19.

This information is rapidly evolving as individual Payers and Health Plans determine specific guidelines around the various areas related to patient communication, clinical evaluation, coding requirements, claims processing, provider credentialing, etc. based on the original CMS 1135 Waiver. However, we would like this FAQ to serve as a baseline document to provide information surrounding the CMS waiver and operational considerations for our clients to maintain optimal outcomes, during a rapidly changing patient experience landscape, due to COVID-19.

> ***Please remember to check with your individual State guidelines for variations to the CMS 1135 Waiver and CARES Act.***

We will cover some of the basics of Telehealth including definitions of terms, types of visits with associated coding, operational strategy, and online resource links.

Let's get started!

What is the difference between “Telehealth” and “Telemedicine”?

Many organizations use the general term “Telehealth” to describe the broader scope of remote healthcare services, which can include delivery of both clinical and non-clinical services. Whereas, “Telemedicine” is typically reserved for describing the actual virtual delivery of a clinical service. For the purposes of this document, we refer to the general term “Telemedicine.”

CMS provides the following description: “Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient’s health. Innovative uses of this kind of technology in the provision of healthcare is increasing. And with the emergence of the virus causing the disease COVID-19, there is an urgency to expand the use of technology to help people who need routine care and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.”

What exactly is the expansion of Telehealth under the CMS 1135 Waiver?

Per CMS Guidelines:

Under this new waiver, Medicare can pay for **office, hospital, and other visits** furnished via telehealth across the country and including in patient’s places of residence **starting March 6, 2020.** A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients.

For some history and context, prior to this waiver Medicare could only pay for telehealth on a limited basis, such as, when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins,** which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits,** which are non-face-to-face patient-initiated communications through an online patient portal.

Under the 1135 Waiver: Medicare beneficiaries will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor’s office or hospital putting themselves and others at risk.

What is the effective date of the expanded services and for how long?

The effective date is **March 6, 2020** and will be covered for the duration under the declaration of the active ***COVID-19 Public Health Emergency.***

What will Medicare cover?

Medicare will make payment for professional services furnished to beneficiaries in all areas of the country, in ALL settings (Any Healthcare facility or in the patient's home).

Please stay up to date on the latest CMS Updates via the CMS Medicare Learning Network MLN Connects link:
https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/Provider-Partnership-Email-Archive

Will Medicare patients be charged their regular co-insurance and deductibles?

Normally, Medicare co-insurance and deductible would apply to these services. However, the HHS Office of Inspector General (OIG) is providing **FLEXIBILITY** to ***REDUCE or WAIVE*** cost-sharing for Telehealth visits paid by federal healthcare programs (March 17, 2020).

Please see the 4/7/2020 update under the Families First Coronavirus Act to WAIVE specific COVID19 related testing services under Medicare Part B utilizing the HCPCS codes U0001, U0002 or 87365.

For more information and guidance, please visit:
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-07-mlnc-se#_Toc37139913

What exactly are the types of "Virtual" services covered under CMS 1135 Waiver?

There are 3 main types of virtual services:

- Medicare Telehealth Visit
- Virtual Check-In
- E-Visit

What is the difference between the 3 types of visits?

Although, the names sound interchangeable, as first glance, each visit has its own purpose, codes and criteria, so let's get to work on those specifics!

1. Medicare Telehealth Visit

Service Method: Provider must use and ***interactive audio and video*** telecommunication system that permits real-time communication between distant site and the patient at home.

Provider Type: Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) **can** include: physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.

Clinical Setting: Any healthcare facility. *Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.*

Covered HCPCS/CPT Codes:

During the PHE, CMS has expanded the services eligible for Telehealth. A complete list of all Medicare Telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Patient Relationship with Provider: New* or Established patients

NOTE: CMS STATEMENT: "It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) 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."

2. Virtual Check-In Visit

Service Method: Services may be furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by ***telephone, audio/video, secure text messaging, email, or use of a patient portal.*** In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPCS code G2010).

Provider Type: Physicians and certain practitioners specified by code

Covered HCPCS/CPT Codes:

- **G2012:** Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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.
- **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, 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.
- UPDATE: For Telephonic Visits, many Payers will accept E+M codes or the 99441-99443 Telephonic visit codes, depending on time. Please refer to your Tracking Payer Guideline Matrix for guidance.
  CMS has increased the Telephonic Visit Fee Schedule reimbursement, retroactive to March 1, 2020. Please refer to the local MAC for specific Fee Schedule rates.

  Announcement link: https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

Patient Relationship with Provider: New and Established patients only

3. E-Visits

Service Method: Communication between a patient and Provider via an online patient portal

Provider Type: Physicians and certain practitioners specified by code

Covered HCPCS/CPT Codes:

E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

- **99421:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- **99422:** Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- **99423:** Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical

psychologists) can also provide these e-visits and bill the following codes:

- **G2061:** Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- **G2062:** Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
- **G2063:** Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

Patient Relationship with Provider: During PHE they are relaxing enforcement of established patient criteria. No review will be conducted to consider if services were performed on established patients

Do the Telehealth 1135 Waiver services require a Modifier and Place of Service?

Update as of 4/3/20:CMS has updated the guideline as follows:

Building on prior action to expand reimbursement for telehealth services to Medicare beneficiaries, CMS will now allow for more than 80 additional services to be furnished via telehealth. When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with:

- Place of Service (POS) equal to what it would have been had the service been furnished in-person
- Modifier 95, indicating that the service rendered was actually performed via telehealth
- As a reminder, CMS is not requiring the CR modifier on telehealth services. However, consistent with current rules for telehealth services, there are two scenarios where modifiers are required on Medicare telehealth professional claims:
- Furnished as part of a federal telemedicine demonstration project in Alaska and Hawaii using asynchronous (store and forward) technology, use GQ modifier
- Furnished for diagnosis and treatment of an acute stroke, use G0 modifier

There are no billing changes for institutional claims; critical access hospital method II claims should continue to bill with modifier GT.

Link to April 3, 2020 Special Edition of MLN Connects:
https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-04-03-mlnc-se

Do the Telehealth 1135 Waiver services apply toward Managed Medicare plans?

Many Managed Medicare Health Plans seem to be including Telehealth services under capitated standard Evaluation and Management services. Please refer to contracted Health Plan guidance.

What is the reimbursement rate for Telehealth 1135 Waiver services?

CMS has stated that telehealth visits are considered the same as regular, face to face visits, reimbursable at the same rate.

Are all Payers set to receive claims under the Telehealth 1135 Waiver expansion?

Each Payer is providing their own guidelines around recommended effective claim submission dates. Please refer to individual Payer guidelines and partnered Clearing House for further direction

What kind of considerations should be made related to waiving the patient share of cost?

Each organization may consider implementing COVID-19 specific administrative adjustment codes with special attention to General Ledger for financial accounting and reporting purposes (i.e. charity). It is unknown if Payers will still carve out the Copay/Deductible/Coinsurance in the remits. As more information becomes available, MediRevv will update this FAQ.

What kind of equipment is needed to provide Telehealth services to patients?

Under the Telehealth 1135 Waiver, the use of telephones which have audio and video capabilities for delivering Telehealth services have been authorized for us, during the COVID-19 PHE. Additionally, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers who serve patients in good faith via everyday communications technologies, such as Facetime or Skype, during the COVID-19 PHE.

Helpful links

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html