COVID-19 UPDATE: EXPANSION OF MEDICARE TELEHEALTH BENEFITS COVERS BROAD ARRAY OF SERVICES AND REDUCES RISKS ASSOCIATED WITH TRAVEL TO HEALTHCARE FACILITIES

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THE TRUMP ADMINISTRATION ANNOUNCES EXPANDED MEDICARE TELEHEALTH COVERAGE

In addition to telehealth services already available to Medicare beneficiaries and their physicians (e.g., "virtual check-ins"), changes made today will significantly increase the ways in which patients can receive COVID-19 care in their own homes. Under the expansion of telehealth 1135 waiver, Medicare coverage has been extended to cover certain services, including evaluation and management ("e/m") visits, office visits, mental health counseling and preventive health screenings. Moving forward, doctors, nurse practitioners, clinical psychologists, licensed clinical social workers and other providers can deliver a broad array of services including using telehealth technology. Providers may begin billing immediately for services rendered starting on March 6, 2020, and can anticipate reimbursement under the Physician Fee Schedule at par with in-person services. These changes do not extend Medicare telehealth service payments to health care facilities beyond the currently available originating site facility fees (HCPCS code Q3014). Billing for Medicare telehealth services remains limited to professionals.

The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) is also providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. A summary of key provisions is provided below.

TYPES OF VIRTUAL SERVICES:

Medicare Telehealth Visits

Medicare has broadened its payment practices, including:

- HHS will implement enforcement discretion where prior established relationships between patients and practitioners are required (HHS will not conduct audits).
- Telehealth visits will be paid at the same rate as regular, in-person visits.
- Medicare is loosening originating site requirements and will now make payment for telehealth services furnished to beneficiaries in any healthcare facility and in their homes.

- Loosening of Medicare coinsurance and deductible requirements - healthcare providers may reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
- Physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals can furnish and get payment for covered telehealth services (subject to state law).

Virtual Check-Ins:

- A patient-provider established relationship is still required for virtual check-in services to be covered.
- Patient initiation requirements relaxed - individual services need to be agreed to by the patient, but practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- Rural settings and other location limitations have been lifted.
- The Medicare coinsurance and deductible would generally apply to these services.
- Audio and visual capabilities for real-time communication are not required - communication technology modalities have been expanded to include synchronous discussion over a telephone or exchange of information through video or image.
- Billing information:
    - HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report e/m 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.
    - HCPCS code 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.

E-Visits:

- A patient-provider established relationship is still required for e-visits to be covered.
- Patient initiation requirements relaxed - individual services need to be agreed to by the patient but practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- Verbal consent required.
- Rural settings and other location limitations have been lifted - no geographic or location restrictions for these visits.
- The Medicare coinsurance and deductible would generally apply to these services.
- Patients may communicate with their doctors through online patient portals.
- Medicare Part B also pays for E-visits or patient-initiated online e/m conducted via a patient portal.
- Billing information:
    - Services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable.

- 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 e/m 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.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):

The HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.

CONCLUSION

Changes made today in Medicare telehealth benefit coverage will help reduce burdens on healthcare institutions across the nation and will assist in allocating resources to the most urgent cases. The CMS fact sheet can be found at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

For questions, please contact a member of our COVID-19 Taskforce.

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