COVID-19 & Virtual Care Services

Background

Shortly after President Trump declared a national emergency due to the novel coronavirus (COVID-19) pandemic, the Centers for Medicare and Medicaid Services (CMS) announced it was using its authority to expand access to virtual care services, including telehealth. According to CMS' communications, these changes are being made "*so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility*" and "*on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act*." A fact sheet and updated FAQ discuss these changes in detail.

On March 30, CMS also announced additional blanket waivers and finalized regulatory changes as part of a COVID-19-focused interim final rule with comment (IFC) to further improve access to virtual care services. A press release and fact sheet provide more information.

Medicare Telehealth Services

Telehealth Expansion with 1135 Waiver and Recent Regulatory Flexibilities

Using its 1135 wavier authority, Medicare can now pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence with dates of services starting March 6, 2020. As described in an agency press release, *"[p]rior to this waiver Medicare could only pay for telehealth on a limited basis: 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."*

In its recent COVID-19 IFC, CMS provides background information on the statutory basis for providing services via telehealth at section 1834(m) of the Social Security Act (the Act); the list of Medicare telehealth services; and the distinction between telehealth services and those commonly furnished remotely using telecommunications technology that are not considered Medicare telehealth services subject to 1834(m) (e.g. remote physician interpretation of diagnostic tests, care management services, and virtual check-ins). CMS also discusses prior steps taken to provide telehealth flexibilities in response to the COVID-19 pandemic, and points to prior rules and regulations at 42 CFR 410.78 and 414.65 to refer to conditions that must generally be met for Medicare to make payment for telehealth services under the Physician Fee Schedule (PFS; p. 12).

Specific to services on the Medicare telehealth list[1], Medicare requires providers to use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. More importantly, CMS clarified that its

[1] On March 30, 2020, and as part of its 1135 waiver authority, CMS updated the list of Medicare telehealth services to include more than 80 additional services.

regulations[2] did not allow "phones" that include audio and video real-time interactive capabilities to qualify as interactive telecommunications systems for the purposes of Medicare telehealth services. In light of the public health emergency, and via the COVID-19 IFC, CMS revised its regulations to add an exception to this language, making these technologies allowable[3].

With respect to payment, CMS also finalized the use of CPT telehealth modifier "95". In its COVID-19 IFC, CMS notes its belief that, *"as more telehealth services are furnished to patients wherever they are located rather than in statutory originating sites, it would be appropriate to assume that the relative resource costs of services furnished through telehealth should be reflected in the payment to the furnishing physician or practitioner as if they furnished the services in person, and to assign the payment rate that ordinarily would have been paid under the PFS were the services furnished in-person."* To implement such a change on an interim basis, CMS is instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person (e.g., POS 11 for office; POS 22 for outpatient facility) and to apply CPT telehealth modifier 95 to claim lines that describe services furnished via telehealth. CMS notes that it is maintaining the facility payment rate for services billed using the general telehealth POS code 02, should practitioners choose to maintain their current billing practices.

Regarding beneficiary cost-sharing, on March 17, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) announced that it would waive enforcement of federal penalties for providers who waive beneficiary cost-sharing requirements for telehealth services during the COVID-19 health emergency. Later, on March 24, OIG issued an FAQ document to clarify that its policy is intended "*to apply to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.*"

Additional information on Medicare telehealth services, in general, can be found in CMS' Medicare Learning Network (MLN) Matters booklet on the telehealth services.

Virtual Check-Ins & Remote Evaluation of Recorded Video, Images

In the CY 2019 Medicare Physician Fee Schedule (MPFS)[4], CMS finalized coding and payment for communication technology-based services, including virtual check-ins and remote evaluation of recorded video and/or images. The HCPCS G-codes for these services are as follows:

[2] 410.78(a)(3)

[3] CMS is adding the following language at § 410.78(a)(3)(i): "Exception. For the duration of the public health emergency as defined in § 400.200 of this chapter, Interactive telecommunications system means multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner."

[4] See pages 59483 to 59489 of the 2019 MPFS Final Rule.

- **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 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.
- **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.

Unlike Medicare telehealth services, virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners and can be conducted with a broader range of communication methods, such as telephone, audio/video, secure text messaging, email, or use of a patient portal. However, given the current public health emergency, CMS finalized that these services, which may only be reported if they do not result in a visit, including a telehealth visit, can be furnished to both new *and* established patients.

In addition, as part of the COVID-19 IFC, CMS finalized that consent to receive these services can be documented by auxiliary staff under general supervision, and can be obtained at the same time that a service is furnished. CMS retained the requirement that in instances when the brief CTBS originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, that this service would be considered bundled into that previous E/M service and would not be separately billable.

Other Digital and eVisits

In the CY 2020 PFS final rule, CMS finalized separate payment for online digital E/M services, as shown below:

- **CPT code 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
- **CPT code 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
- **CPT code 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
- **HCPCS code G2061**: Qualified nonphysician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- **HCPCS code G2062**: Qualified nonphysician 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

- **HCPCS code G2063**: Qualified nonphysician 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

Similar to the circumstances outlined above, and as discussed in the COVID-19 IFC, CMS will exercise enforcement discretion on the "established" patient aspect of these services and will not conduct reviews to consider whether those services were furnished to established patients.

In addition, CMS previously stated that HCPCS codes G2061-G2063, which are specific to practitioners who do not report E/M codes and may describe services outside the scope of current Medicare benefit categories, and as such, may not be eligible for Medicare payment. However, CMS clarified that there are several types of practitioners who could bill for these codes (e.g., licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services).

Of note, in the COVID-19 IFC, CMS also broadened the availability of HCPCS codes G2010 and G2012 to the aforementioned practitioners outlined above.

Telephone E/M Services

In the COVID-19 IFC, CMS finalized separate payment for "telephone" E/M services, as outlined below:

- **CPT code 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
- **CPT code 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
- **CPT code 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
- **CPT code 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

- **CPT code 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
- **CPT code 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

CMS previously finalized relative values recommended by the AMA Health Care Professionals Advisory Committee (HCPAC) and AMA Relative Value Scale Update Committee (RUC) in its CY 2008 PFS final rule[5]. However, as part of an April 30th interim final rule, CMS increased payment for audio-only telephone E/M services by increasing work RVUs and direct practice expense inputs based on crosswalks to office/outpatient E/M codes (cross-walking 99441-3 to 99212-4, respectively).

Similar to other virtual care services, CMS is exercising enforcement discretion and will not conduct review to consider whether those services were furnished to established patients, thus, they may be used for both new *and* established patients.

Selecting the Level of Office/Outpatient E/M Visits Delivered via Medicare Telehealth

In the COVID-19 IFC, CMS discusses policies finalized in the CY 2020 PFS Final rule for January 1, 2021, for office/outpatient E/M visits, including policies for selecting code level based on either the level of medical decision making (MDM) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time). These policies are not in effect until 2021, and the current E/M guidelines would preclude the billing practitioner from selecting office/outpatient E/M code levels based on time in circumstances where the practitioner is not engaged in counseling and/or care coordination.

However, given the current public health emergency, CMS revised its policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record. This policy is similar to the policy that will apply to all office/outpatient E/Ms beginning in 2021 under policies finalized in the CY 2020 PFS final rule. It remains CMS' expectation that practitioners will document E/M visits as necessary to ensure

[5] 72 CFR 66371

quality and continuity of care. To reduce the potential for confusion, CMS is maintaining the current definition of MDM.

CMS notes that currently there are typical times associated with the office/outpatient E/Ms, and CMS finalized those times as what should be met for purposes of level selection[6]. CMS notes that this policy only applies to office/outpatient visits furnished via Medicare telehealth, and only during the PHE for COVID-19.

When using time alone to determine code level, the following minimums must be met:

New Patients			Established Patients		
CPT Code	**CPT Typical Time**	**CMS Typical Time**	**CPT Code**	**CPT Typical Time**	**CMS Typical Time**
99201	10 minutes	17 minutes			
99202	20 minutes	22 minutes	99212	10 minutes	16 minutes
99203	30 minutes	29 minutes	99213	15 minutes	23 minutes
99204	45 minutes	45 minutes	99214	25 minutes	40 minutes
99205	60 minutes	67 minutes	99215	40 minutes	55 minutes

As a reminder, time is all of the "physician time" (face-to-face and non-face-to-face) associated with the E/M service on the day of the encounter; time with clinical staff should not be included.

Modalities for Virtual Care Services

On March 13, HHS Secretary Azar waived certain requirements, retroactive nationwide as of March 6, related to HIPAA privacy. Then, on March 17, the HHS Office of Civil Rights (OCR) announced enforcement discretion for certain widely used "non-public facing" communications, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19. Further, a related OCR FAQ states that the use of certain "public facing" platforms, such as Facebook Live, Twitch, and TikTok, are unacceptable forms of remote communication for telehealth and "may consider a bad faith provision of telehealth services" and therefore note be covered by OCRs enforcement discretion.

Working from Home

On March 30, CMS issued additional blanket waivers, one of which will allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location. See CMS' Provider Enrollment FAQ (Question 12) for details.

[6] On a recent CMS "Office Hours" teleconference, the agency noted that use of CPT typical times was allowable.

Resources from the AMA

In response to the Medicare changes, the American Medical Association (AMA) shared the Quick Guide to Telemedicine in Practice, a new resource to help mobilize remote care with implementation tips, as well as a reference to Current Procedural Terminology (CPT®) codes for reporting telemedicine and remote care services. The AMA also offers an education module in the AMA's STEPS Forward™ that can help physicians use telemedicine in practice, and the Digital Health Implementation Playbook with a 12-steps process for adopting remote monitoring of patients outside the traditional clinical environment.

Key Limitations and Other Considerations

State Licensing and Interstate "Compacts"

Given challenges with clinicians providing care across state lines, the Federation of State Medical Board (FSMB) established the Interstate Medical License Compact Commission (IMLCC). According to IMLCC, *"[t]he Interstate Medical Licensure Compact offers a new, voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states."* At this time, 29 states, the District of Columbia and the Territory of Guam, have agreed to the compact. Additional information about FSMB and telemedicine policy is available here.

Also, according to the FSMB' Telemedicine Policies Overview, twelve (12) state medical (or osteopathic) boards issue special licenses or certificates related to telehealth. As explained by the Center for Connected Health Policy of the National Telehealth Policy Resource Center report, State Telehealth Laws & Reimbursement Policies, the licenses could allow an out-of-state provider to render services via telemedicine in a state where they are not located, or allow a clinician to provide services via telehealth in a state if certain conditions are met (such as agreeing that they will not open an office in that state).

At this time, CMS has approved Section 1135 waivers for 34 states. According to the Kaiser Family Foundation (KFF), 31 states' waivers allow out-of-state providers with equivalent licensing in another state.

Credentialing and Out-of-Network (OON)

Despite waivers of certain licensure requirements to allow for Medicare and Medicaid payments to providers who do not have a license within that State, these waiver does not extend to non-Federal programs (including ERISA plans). Also, are regardless of state licensure, private payers have additional requirements regarding credentialing. As a result, out-of-state providers are likely to be considered out-of-network (OON).

Prescribing Controlled Substances

On March 20, the Drug Enforcement Agency (DEA) issued a press release noting that DEA-registered practitioners may use telehealth during the public health emergency for the prescription of controlled substances, provided that:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice.

- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.

On March 25, the DEA granted an exception to the requirement that a DEA registrant must be registered in each state in which the practitioner dispenses controlled substances. Under this exception, DEA-registered practitioners are not required to obtain additional registration with the DEA in the additional state(s) where the dispensing (including prescribing and administering) occurs, for the duration of the public health emergency if they are registered in at least one state and have permission under state law to practice using controlled substances in the state where the dispensing occurs, including for the practice of telemedicine. Additional detail is in the linked notice.

On March 27, the DEA announced exceptions to requirements regarding paper delivery of a prescription of an oral emergency prescription, including allowing the prescription to be sent via facsimile, or for the prescription to be photographed, scanned, and sent in place of the paper prescription.

On March 31, 2020, the DEA announced that it is providing flexibility to provide buprenorphine to new and existing patients with opioid use disorder (OUD) for maintenance and detoxification treatment via telephone by otherwise authorized practitioners without requiring such practitioners first conduct an examination of the patient in person or via telemedicine. This policy is effective from March 31, 2020 through the duration of the PHE.