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Delaware Valley ACO Telehealth Toolkit

COVID-19 Public Health Emergency: Telehealth Services

On March 17, 2020, CMS stated that it will immediately expand coverage for telemedicine nationwide. Under Section 1135 of the Social Security Act, CMS temporarily waives certain Medicare, Medicaid, SCHIP, HIPAA requirements. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services for patients that are in their homes or any setting of care. The waiver is expected to expire when the underlying emergency/disaster declaration terminates.

What Practices Need to Know

Items that are <u>temporarily waived/suspended</u> through the blanket waiver

- Prior authorization requirements for fee-for-service programs
- Requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state (this applies to Medicare and Medicaid)
- Certain provider enrollment and revalidation requirements to increase access to care
- Requirements for certain pre-admission and annual screenings for nursing home residents

Telehealth Services Provided Under the Current Emergency Declaration

Telehealth services are paid under the Physician Fee Schedule (PFS) at the same amount as in-person services. As of 3/30/20, the claim for these non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency, providers should bill with the Place of Service code equal to what it would have been in the absence of the public health emergency, along with a modifier 95, indicating that the service was performed via telehealth. Medicare coinsurance and deductibles still apply for these services; however, the Health and Human Services (HHS) Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

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Medicare Service	What Does the Service Entail?	Modalities Allowed	Billing (HCPCS/CPT Codes) Dates of service starting 3/6/20	Patient Relationship with Provider	Eligible Patients
Telehealth Visits	• A visit/appointment between provider and patient via telecommunication systems ➢ CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication ➢ CMS is allowing audio only equipment for certain Telehealth Services • Examples: ➢ Evaluation and Management Visits ➢ Mental Health Counseling ➢ Preventive Health Screenings ➢ Prescription Refills ➢ Chronic Care Management	• **Applications Allowed:** ➢ Apple FaceTime ➢ Facebook Messenger video ➢ Google Hangouts video ➢ Zoom ➢ Skype • **Applications <u>Not</u> Allowed:** ➢ Applications that are public facing ➢ Facebook Live ➢ Twitch ➢ TikTok	**Common Codes**: • 99201-99215 (Office or other Outpatient Visits) • G0425-G0427 (Telehealth Consultations, Emergency Department or Initial Inpatient) • G0406-G0408 (Follow-up Inpatient Telehealth consultation to patients in hospitals or SNFs) • Link to Complete List of Billable Telehealth Codes • Medicare coinsurance and deductible apply	• Physicians • Qualified Health Care Professionals who can report evaluation and management services (Examples: Nurse Practitioners, Physician Assistants, etc.) • Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)	• Established patients • New patients
Virtual Check-Ins	• A brief (5-10 minutes) check-in with the provider via telephone or other telecommunication devices, such as video or images to decide whether an office visit or other visit is needed • The check-in is not related to a medical visit provided within the previous 7 days nor leading to a visit or procedure within the next 24 hours, or next available appointment • As of 3/30/20- Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.	• **Patient Submission:** ➢ Use a device like a phone, integrated audio/video system, or captured video image to communicate with provider • **Provider Response:** ➢ Follow- up with the patient can take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication	• HCPCS Code G2012 • HCPCS Code G2010 • Medicare coinsurance and deductible apply	• Physicians • Qualified Health Care Professionals who can report evaluation and management services • Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)	• Established patients • New patients
E-Visits	• A communication between a patient and their provider through an online patient portal • The patient must generate the initial inquiry and communications can occur over a 7-day period • The patient must verbally consent to receive this service	• Patient Portal	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063 • Medicare coinsurance and deductible apply	• Physicians • Qualified Health Care Professionals who can report evaluation and management services • Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)	• Established patients
Telephone E/M Visits	• A communication between a patient or caregiver and their provider (between 5-30 minutes of medical discussion) on the telephone • Cannot be related to a medical visit provided within the previous 7 days nor leading to a visit or procedure within the next 24 hours, or next available appointment	• Telephone	• 99441 • 99442 • 99443 • 98966 • 98967 • 98968	• Physicians • Qualified Health Care Professionals who can report evaluation and management services • Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists)	• Established patients

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Key Takeaways

1. **Telehealth Visits**
    - Patients in all areas of the country can receive telehealth services, including at their home
    - Telehealth services are not only limited to services related to patients with COVID-19
    - Medicare will make payments effective for services starting 3/6/20, and for the duration of the COVID-19 Public Health Emergency, for any professional services to patients in any healthcare facility and in their homes
    - Visits are considered the same as in-person office visits and are paid the same rate as in-person office visits
    - Can be provided by a non-public facing remote communication product that is available to communicate with patients
    - The Department of Health and Human Services (HHS) will not conduct audits to ensure a prior relationship between patient and provider existed for claims submitted during public health emergencies
    - CMS recommends the patient verbally consent to receive this service
    - Medicare coinsurance and deductible would apply to these services
    - As of 3/30/20, physicians can now declare patients homebound if they do not leave home because of a medical contraindication or due to suspected or confirmed COVID-19
    - As of 3/30/20, CMS added more than 80 additional services that can be delivered through telehealth, including emergency department visits, initial nursing facility and discharge visits, and home visits
        - As of 4/30/20, more than 40 additional codes were added to the list of services that can be provided by telehealth
    - As of 3/30/20, claims for non-traditional telehealth services with dates of services on or after 3/1/20, and for the duration of the Public Health Emergency, providers should bill with the Place of Service code equal to what it would have been in the absence of the public health emergency, along with a modifier 95, indicating that the service was performed via telehealth
    - As of 4/30/20, Qualified Non-Physician Health Care Professionals (Examples: Physical Therapists, Occupational Therapists, Speech Language Pathologists, Clinical Psychologists) can deliver telehealth services
    - As of 4/30/20, CMS will allow the use of audio-only equipment to more than 80 telehealth services; including Medicare Annual Wellness Visits

2. **Virtual Check-Ins**
    - Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication
    - This service is not limited to only rural settings or certain locations
    - Medicare coinsurance and deductible would apply to these services
    - As of 3/30/20, annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.
    - As of 3/30/20, the Department of Health and Human Services (HHS) will not conduct audits to ensure a prior relationship between patient and provider existed for claims submitted during public health emergencies

- As of 3/30/20, services billed by practice occupational therapist, physical therapist, and speech-language pathologist must include the corresponding GO, GP, or GN therapy modifier on claims

3. **E-Visits**
   - Patients communicate with their providers by using online patient portals
   - Individual services need to be initiated by the patient and communications can occur over a 7-day period. Providers may educate patients on the availability of the service prior to patient initiation
   - This service is not limited to only rural settings or certain locations
   - Services can only be reported when the billing practice has an established relationship with the patient
   - Patients must verbally consent to this service. Providers can educate patients on the availably of the service prior to consent
   - Medicare coinsurance and deductible would apply to these services
4. **Telephone E/M Visits**
   - This service is not limited to only rural settings or certain locations
   - Services can only be reported when the billing practice has an established relationship with the patient
   - HHS will not conduct review to consider whether those services were furnished to established patients
   - Services billed by practice Occupational Therapist, Physical Therapist, and Speech-language Pathologist must include the corresponding GO, GP, or GN therapy modifier on claims
   - As of 4/30/20, CMS increased reimbursement for CPT codes 99441-99443 from a range of about $14-$41 to about $46-$110. The payments are retroactive to 3/1/20
     - Updated 6/1/20: Medicare Administrative Contractors (MACs) will reprocess claims for those services that they previously denied and/or paid at the lower rate for dates of service on or after 3/1/20
   - As of 4/30/20, CMS is paying for Medicare telehealth services provided by Rural Health Clinics and Federally Qualified Health Clinics (FQHCs)

Telehealth Services Updates from Our Other Payers

*Sources: Letters from Payers and References below

***Information below only includes updates for payers in DVACO contracts. Contact payers or refer to available payer guidance documents for additional information or questions regarding contracts not included in the below updates.*

Aetna

1. **Billing Guidance**
   - Telemedicine services can be offered for any reason, not just COVID-19 diagnosis
   - Telemedicine Policy is available to providers on the Availity and NaviNet portals
   - As of 4/17/20, all providers will be reimbursed for telemedicine at the same rate as in-person visits

- As of 4/17/20, telemedicine will be covered within the capitation agreement, similar to an in-office visit
- As of 4/17/20, telephone only codes (99441-99443, 98966-98968, G2010, G2012) do not equate to an office visit, they will not result in an office visit reimbursement rate
- As of 4/17/20, physicians may provide care from any location if they follow Aetna's telemedicine policy. Physicians should continue to bill using their currently enrolled location and should not use their home address
- As of 5/13/20, covering appropriate evaluation and management codes with a wellness diagnosis for those aspects of the visit done via telehealth
    - Preventative visit codes should be reserved for such time when routine in-office visits resume, and the remaining parts of the well visit can be completed. Both services will be fully reimbursed, and the patient will not incur cost-sharing
- Commercial Plans:
    - Updated 5/18/20: Non-facility telemedicine claims must use POS 02 with the GT or 95 modifier
    - Continuing to cover limited minor acute care evaluation and care management services, as well as some behavioral health services rendered via telephone-only until 8/4/20
    - A synchronous audiovisual connection is required for general medicine and some behavioral health visits
- Medicare Advantage:
    - Updated 5/18/20: Non-facility telemedicine claims must use POS 02 or POS 11, or the POS equal to what it would have been if the service was rendered in-person, along with a modifier 95 indicating that the service rendered was actually performed via telehealth
    - Audio-only telemedicine services can be billed for a limited number of codes

2. Cost-Sharing Waivers

- Commercial Plans:
    - Waiving member cost-sharing for in-network covered telemedicine visit, regardless of diagnosis, until 6/4/20
    - Extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services through 9/30/20 (Self-insured plans can offer this waiver at their own discretion)
    - Waiving cost-sharing for covered real-time virtual visits (live video-conferencing and telephone-only telemedicine services) offered by in-network providers (Self-insured plan sponsors can offer this waiver at their discretion)
- Medicare Advantage:
    - Waiving cost-sharing for primary care and behavioral health telemedicine visits with network providers through 9/30/20
    - Waiving member out-of-pocket costs for all in-network primary care visits, whether done in-office and via telehealth, for any reason, and encourages member to continue seeking essential preventive and primary care during the crisis through 9/30/20
    - Waiving cost-sharing for real-time virtual visits offered by in-network providers (live video conferencing or telephone-only telemedicine services)
    - The no-cost telemedicine benefit only applies to real-time virtual care delivered by in-network providers

3. **Diagnostic Testing/COVID-19 Treatment**
    - As of 5/1/20, waiving cost-sharing for diagnostic testing related to COVID-19
        - This policy covers the cost of a physician-ordered test and the office, clinic, or emergency room visit that results in the administration of or order for a COVID-19 test. The test can be done by any approved laboratory
    - Member cost-sharing waiver applies to all Commercial, Medicare and Medicaid and self-insured plans. All Commercial and Medicaid plans must cover antibody testing with no cost-sharing
    - Paying the amount of the cost-sharing the member would have ordinarily paid so the provider would receive the same total payment
    - Updated 5/13/20: Waiving member cost-sharing for inpatient admissions for treatment of COVID-19 or health complications associated with COVID-19. This applies to all Commercial and Medicare Advantage plans and is effective immediately for any admission through 9/30/20
    - Updated 5/13/20: Covering the full cost of provider in office treatment of COVID-19 for Medicare Advantage members
4. **Prescription Coverage**
    - Waiving early refill limits on 30-day prescription maintenance medications and charges for home delivery of prescription medications for all members with pharmacy benefits administered through CVS Caremark through 5/1/20
    - Offering 90-day maintenance medication prescriptions for insured and Medicare members

Humana

1. **Billing Guidance**
    - Temporarily reimbursing for telehealth visits with participating and in-network providers at the same rate as in-office visits
        - Providers should bill with the Place of Service code that would have been used if the service had been rendered in person along with a modifier 95
        - As of 4/9/20, reimbursing the full amount allowed for all covered services, including telehealth and other virtual services, rendered by in-network and out-of-network providers, billed with a COVID-19 related diagnosis code; this includes any member cost-sharing that would have otherwise applied
    - A customer service concierge line for members with questions related to the coronavirus and their coverage has been established
        - Members can call Humana's customer support line listed on the back of their member ID card for any questions
    - As of 5/5/20, for providers or patients that do not have access to secure video systems, telephone (audio-only) visits will be accepted. These visits can be submitted and reimbursed as telehealth visits
    - As of 5/5/20, participating and in-network primary and specialty providers can render care using telehealth services, as long as CMS and state-specific guidelines are followed
    - As of 5/15/20, increasing rates for the Medicare and other fee schedules that are based on current Medicare allowable amounts, for telephone E/M services. Increases will apply to services provided during the PHE, for dates of service beginning 3/1/20

- As of 5/15/20, some services that are coverable when provided using real-time, interactive audio-video telecommunications are also coverable when video was not used; however, because video is clinically significant to services that normally require face-to-face interaction, such services provided without video are only coverable when it was impossible to use video
    - Example: Public health emergency exceptions to normal requirements, designed to ensure that patients receive critical services in unprecedented times, do not imply when otherwise-applicable standards can be ignored when it is practical to continue to meet them
- As of 5/15/20, FQHCs can bill telehealth and other virtual services. A modifier 95 should be used to indicate the service was provided via telehealth

2. Cost-Sharing Waivers

- As of 5/5/20, waiving all cost-sharing including copays, coinsurance, and deductibles for in-network primary care, behavioral health, and telehealth visits effective 5/1/20 through the remainder of the 2020 calendar year
- Waiving copays, deductibles, and coinsurance cost-sharing for covered services for COVID-19 related tests and treatments regardless of where they take place
    - Includes telehealth, primary care physician visits, specialty physician visits, facility visits, labs, home health and ambulance services for the following plans: Individual and Group Medicare Advantage, Medicare supplement fully-insured group commercial, Medicaid employee health plans
- Beginning 3/10/20 and for the next 90 days, temporarily waiving member out-of-pocket costs for telehealth visits with participating in-network providers, including routine visits for primary and specialty care, and behavioral health services
- As of 4/13/20, the effective date of the expansion of coverage of telehealth and other virtual services is 3/6/20. The effective date of the waivers for COVID-related cost-share is 2/4/20
    - The changes will be applied retroactively to claims previously submitted for dates of service on and after the relevant effective date(s)

3. Diagnostic Testing/COVID-19 Treatment

- As of 3/29/20, preauthorizations for care have been removed in many cases
    - Medicare Advantage and employer-plan members who test positive for COVID-19 do not need a preauthorization to begin treatment immediately

4. Prescription Coverage

- Updated 5/13/20: Beginning 3/10/20, early prescription refills are allowed through 7/25/20 for members with prescription drug coverage; and an extra 30- or 90-day supply as appropriate

5. Miscellaneous

- Annual Wellness Visits can be provided through telehealth services as long as they are consistent with CMS guidelines, state guidance, and Humana's policy
- As of 4/9/20, a member does not need to be an established patient of the provider

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- As of 4/13/20, the Practitioner Assessment Form (PAF) (CPT code 96160) can be completed through telehealth or other virtual technology. Telehealth visits using real-time interactive audio only will be accepted
- As of 4/13/20, telephonic and interactive video/audio consultations can be administered for the following measures:
  - Medication Reconciliation Post-Discharge
  - Care for Older Adults- Medication Review, Functional Status Assessment, Pain Screening, and Advance Care Planning
  - Comprehensive Diabetes Care- Medical Attention for Nephropathy, but only if the telehealth visit is with a nephrologist
  - Transitions of Care
  - Follow-up after Emergency Department Visit for Patients with Multiple Chronic Conditions
- As of 4/13/20, information can be gathered from patients during a telehealth visit regarding the administration and results of prior care. Submission of medical records with this care documented addresses these measures:
  - Comprehensive Diabetes Care- Eye Exam and Blood Sugar Controlled
  - Breast Cancer Screening
  - Colorectal Cancer Screening
- Link to Physician Telehealth FAQ
- As of 5/1/20: Risk Adjustment Information Table

COVID-19 telehealth and other virtual services that are eligible for risk adjustment

Technology solution/visit type	Medicare-covered services	Qualifies for risk adjustment	Equivalent to face-to-face visit	Physician location	Submission POS[1]	Common CPT®[2] and HCPCS[3] codes
Telehealth with interactive audio and video	✓	✓	✓	Home/office/facility	Use CPT telehealth modifier "95" with any POS	99201 – 99215 (office or outpatient visits) G0425 – G0427 (telehealth consultations, emergency department or initial inpatient)
Telephonic visit (audio only)	✓	✗	✗	Home/office/facility	Any POS	99441 -- 99443
Virtual check-in (5 – 10 min. visit)	✓	✗	✗	Home/office/facility	Any POS	G2010 and G2012
E-visit (use of patient portal)	✓	✗	✗	Home/office/facility	Any POS	99421, 99422, 99423, G2061, G2062 and G2063

For a complete list, visit: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Diagnoses resulting from telehealth services can meet the risk adjustment face-to-face requirement when the services are provided using an interactive audio and video telecommunications system that permits real-time interactive communication.

[1] POS = place of service [2] CPT® = Common Procedural Terminology [3] HCPCS = Healthcare Common Procedural Coding System

Source: Centers for Medicare & Medicaid Services (CMS), Dept. of Health & Human Services (HHS), April 10, 2020

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UnitedHealthcare

1. **Billing Guidance**
    - Providers may bill telehealth services that are provided by HIPAA approved telehealth technologies and other populations applications that allow for video chats such as FaceTime, Facebook Messenger and Skype
        - Applications that are public facing, such as TikTok, Facebook Live, Twitch and Snapchat, cannot be used
    - For telehealth visits, providers should bill with the Place of Service code equal to what it would have been in the absence of the public health emergency, along with a modifier 95, GT, or GQ
    - Expanded the list of clinicians that can provide telehealth services to include physical, occupational, speech, and chiropractic therapists
    - Allowing all codes on the CMS Covered Telehealth Services list during the public health emergency for Medicare Advantage, Medicaid, and Individual and Group Market health plans
    - Allowing additional codes to be used for telehealth for Preventive Medicine and Applied Behavior Analysis for Medicaid and Individual and Group Market health plans: Link to additional billable codes
    - Additional covered codes can be found in the Medicaid and Individual and Group Market Health Plans Telehealth and Telemedicine Reimbursement policies and plans
    - Individual/Group Market Plans:
        - Note: Medicare Advantage Plan and Medicaid policy/requirements may vary from Individual/Group plans. Link to Refer for Updated Policies
        - Originating site or audio-video requirements that may apply under reimbursement policies are waived so that telehealth services provided by a live audio-video or audio-only communication system can be billed for members at home or another location
            - Updated 6/17/20: Waived from 3/18/20 through 9/30/20 for Individual and Group Market health plans
        - Updated 6/17/20: Will reimburse providers for telehealth visits at parity with the rate they would receive for an in-person visit through 9/30/20
            - Updated 6/17/20: Provider Billing Guidance as of 6/15/20
        - Telehealth services performed using either interactive audio-video or audio only, except in the cases where we have explicitly denoted the need for interactive audio-video
            - Example: PT/OT/ST while a patient is at home
    - Updated 6/17/20: Reference Guide for beginning and end dates of program, process and procedure changes as a result of COVID-19 can be found here: Summary of COVID-19 Dates by Program
        - Information is current as of 6/17/20
    - Updated 6/17/20: The scenarios in the coding guidance document apply for dates of service from 5/13/20-9/30/20
        - Link to UnitedHealthcare Coding Guidance Document

- Updated 6/17/20: Virtual check-ins can be billed for patients with Individual and Group Market health plans and Medicare Advantage plans from 5/13/20-9/30/20
  - The patient must verbally consent to receive services
  - Services are for new and established patients
  - Services cannot be related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available)
- Updated 6/17/20: Individual and Group Market health plans will reimburse for E-Visits from 5/13/20- 9/30/20
  - The patient must verbally consent to receive services
  - Services are for established patients
  - Services cannot be related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available)
- Updated 6/1/20: Claims with a date of service on or after 1/1/20 will not be denied for timely filing if submitted by 6/30/20

2. Cost-Sharing Waivers

- Updated 6/17/20: Waiving cost-sharing for in-network telehealth services for COVID-19 and non-COVID-19-related visits for medical, outpatient behavioral and PT/OT/ST services from 3/31/20 through 9/30/20 for members with Medicare Advantage, Medicaid and Individual and Group Market health plans
  - This date is subject to change based on direction from CMS

3. Diagnostic Testing/COVID-19 Treatment

- Updated 6/17/20: Waiving cost-sharing for COVID-19 testing and the testing-related visit for Medicare Advantage, Medicaid, Individual and Group Market health plan members through the Public Health Emergency
  - This includes a visit to a health care provider's office, an urgent care center, an emergency department or a telehealth visit
- Updated 5/29/20: Waiving cost-sharing for COVID-19 treatment for Medicare Advantage, Medicaid, Individual and Group Market fully insured health plan members until 7/24/20

4. Prescription Coverage

- Updated 5/29/20: Allowing early prescription refills (up to a 90-day refill) for eligible UnitedHealthcare and OptumRx members through home delivery and select retail pharmacies until 6/15/20
- Updated 6/17/20: Allowing a 90-day extension, based on original authorization date, of open and approved prior authorizations with an end date or date of service between March 24, 2020 and May 31, 2020, for services at any care provider setting

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