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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 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 10/15/20, as of 10/14/20, CMS added 11 new services to the Medicare telehealth services list
    - 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 (AWV)
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 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
        - As of 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 and their websites 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 portal
- As of 4/17/20, all providers will be reimbursed for telemedicine at the same rate as in-person visits included behavioral services, with the exception of some telephone-only services in commercial plans
    - As of 10/4/20, telephone only services 99441-99443 are now set to equal 99212- 99214 (e.g.- 99441 is set to equate to 99212)
- As of 4/17/20, telemedicine will be covered within the capitation agreement, similar to an in-office visit
- 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:
    - As of 8/4/20, continuing to cover limited minor acute care evaluation and care management services and some behavioral health services rendered via telephone-only until 12/31/20
    - A synchronous audiovisual connection is required for specialty, most general medicine and some behavioral health visits
    - As of 8/4/20, Aetna's liberalized coverage of Commercial telemedicine services will now extend through 12/31/20
        - Specific details are outlined on the Telemedicine policy available on Availity
    - As of 5/18/20, non-facility telemedicine claims must use Place of Service (POS) 02 with the GT or 95 modifier
- Medicare Advantage:
    - As of 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 performed via telehealth
    - Audio-only telemedicine services can be billed for a limited number of codes

2. Cost-Sharing Waivers

- Commercial Plans:
    - As of 10/4/20, extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services through 12/31/20 (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:
    - As of 10/4/20, extending all member cost-sharing waivers for covered in-network telemedicine visits for outpatient and mental health counseling services through 12/31/20

- As of 10/4/20, waiving cost sharing for in-network primary care and specialist telehealth visits, including outpatient behavioral and mental health counseling services through 12/31/20
- As of 10/4/20, 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 12/31/20
- 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 10/4/20, 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 12/31/20
- As of 10/4/20, covering the cost of the hospital stay for all Medicare Advantage members admitted 3/25/20 through 12/31/20
- 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
- As of 5/13/20, covering the full cost of provider in office treatment of COVID-19 for Medicare Advantage members

4. Prescription Coverage

- As of 10/4/20, waiving early refill limits on 30-day prescription maintenance medications for all Commercial members with pharmacy benefits administered through CVS Caremark
- As of 10/4/20, Aetna Medicare members may request early refills on 90-day prescription maintenance medications at retail or mail pharmacies if needed
  - For drugs on a specialty tier, early refill limits for a 30-day supply are waived

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 POS code that would be used if the service was 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

- Waiving all cost-sharing including copays, coinsurance, and deductibles for in-network primary care and specialty telehealth visits, including behavioral health, effective 5/1/20 through the remainder of the 2020 calendar year for Medicare Advantage Members
- Waiving in-network primary care costs, not only for COVID-19 costs, but all primary care visits for the rest of 2020 calendar year for Medicare Advantage Members
  - Includes services are delivered through office, clinic, telehealth or in-home visits
  - Cost share will not be waived for services provided in urgent care centers
- Waiving member costs for outpatient, non-facility based behavioral health visits through the end of year for Medicare Advantage Members
  - Eligible visits include individual therapy, psychiatric medication consultations and group therapy in an outpatient, non-facility basis
- Waiving copays, deductibles, and coinsurance cost-sharing for covered services for COVID-19 related tests and treatment of confirmed cases of COVID-19 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

3. Diagnostic Testing/COVID-19 Treatment

- Updated 10/21/20: Reinstating authorization requirements on COVID-19 diagnoses for Medicare Advantage and commercial plans for authorizations requested on or after 10/24/20
  - There are no prior authorization requirements related to COVID-19 testing

4. **Prescription Coverage**
    - As of 3/10/20, early prescription refills are allowed for members with prescription drug coverage; and an extra 30- or 90-day supply as appropriate
5. **Miscellaneous**
    - AWVs can be provided through telehealth services as long as they are consistent with CMS guidelines, state guidance, and Humana's policy
    - As of 7/1/20, Humana will no longer accept PAFs completed during a visit using real-time interactive audio-only technology, but will continue to accept visits conducted using a real-time interactive audio and video telecommunications system
        - As of 7/1/20, a visit performed using audio-only technology should be billed with telephonic evaluation and management codes (99441-99443)
    - 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
    - Updated 10/21/20: Humana has started new programs to support care through the pandemic
        - Access to at-home and drive-thru COVID-19 testing
        - At-home preventive screening kits
        - Proactive care outreach to support members' social needs
        - Supporting access to care for flu shots
    - Link to Physician Telehealth FAQ
    - As of 5/1/20, Risk Adjustment Information Table

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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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