Regulatory Compliance in Telehealth during the COVID-19 Public Health Emergency (PHE)

INTRODUCTION AND OUTLINE

The expansion of telehealth benefits due to the coronavirus presents a revenue opportunity for practices and increased care for patients. However, these opportunities are accompanied by quickly changing guidelines, which could result in future regulatory risk for providers. In this white paper, the Marwood Group addresses how to handle these compliance challenges. The information presented is broken down into the following sections:

I. PROBLEM STATEMENT

CMS is expanding the telehealth benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. The benefits are part of its broader effort to ensure that all Americans – particularly those at high-risk of complications from the virus that causes COVID-19 – are aware of easy-to-use, accessible benefits that can help keep them healthy, while helping to contain the community spread of this virus.

This expanded use of technology creates opportunities for providers from both a patient care perspective and the potential for a new or enhanced revenue stream. However, ongoing changes in payor requirements for coding, billing, and the required clinical documentation may present challenges for clinicians and office staff during these trying times. Failure to properly address these changes may impact on cash flow today and may create risk of repayment or recoupment in the event of payor scrutiny in the future.

II. BACKGROUND

1135 Waiver: When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions that may go beyond their regular authorities. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health

Insurance Program (CHIP) requirements to ensure that sufficient healthcare items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods. This also guarantees that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).

Examples of areas that may be changed or modified as a result of an 1135 waiver include:

- Conditions of Participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other healthcare professionals be licensed in the state in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – state law governs whether a non-Federal provider is authorized to provide services in the state without state licensure)
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived)
- Limitations on payment for healthcare items and services furnished to Medicare Advantage enrollees by non-network providers

Expansion of Telehealth with 1135 waiver: Telehealth services include office visits, psychotherapy, consultations, and certain other medical or health services that are provided by an eligible provider who isn't at the patient's location, using an interactive two-way telecommunications system (like real-time audio and video). With the emergence of the virus causing COVID-19, there is an urgency to expand the use of technology to help people who need routine care and keep vulnerable beneficiaries and those with mild symptoms in their homes while still able to maintain access to the care they need. Telehealth can help limit community spread of the virus, as well as the exposure to other patients and staff.

CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Prior to this waiver, Medicare only paid for telehealth services on a limited basis.

Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country – including when the patient is in his/her place 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 services to their patients.

As a result of the Coronavirus (COVID-19) Public Health Emergency, doctors and other healthcare providers can use telehealth services to treat COVID-19 (and for other medically reasonable purposes) from offices, hospitals, and places of residence (like homes, nursing homes, and assisted living facilities). 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, rather than having to go to a doctor's office or hospital, which would force them to put themselves and others at heightened risk.

Telemedicine spans a continuum of technologies that offer new ways to deliver care including:

- Real-time, audio-video communication tools (telehealth) that connect physicians and patients in different locations

- Store-and-forward technologies that collect images and data to be transmitted and interpreted later
- Remote patient-monitoring tools, such as blood pressure monitors, Bluetooth-enabled digital scales, and other wearable devices that can communicate biometric data for review (which may involve the use of mHealth apps)
- Verbal/Audio-only and virtual check-ins via patient portals, messaging technologies, etc.

III. IMPLEMENTATION OF TELEHEALTH SERVICES

Under this expansion of telehealth services, the following steps should be taken by providers as part of their implementation plan. Providers should:

- Check with their malpractice insurance carrier to confirm their policy covers providing care via telemedicine
- Familiarize themselves with payment and policy guidelines specific to various telemedicine services
- Vendor evaluation, selection, and contracting Evaluate, select, and contract with vendors
- Manage Workflow and Patient Care
    - Develop written protocols for if/when a telehealth visit is appropriate
    - Determine when telehealth visits will be available on the daily schedule (*i.e.*, throughout the day intermixed with in-person visits, or for a set block of time specifically devoted to virtual visits)
    - Set up space in your practice to accommodate telehealth visits
    - Ensure you are properly documenting these visits

IV. COMPLIANCE

HIPAA: Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide Public Health Emergency.

Consent: Providers and suppliers should ensure they receive advance consent from patients for telemedicine interactions. This should be documented in the patients' records.

Provider licensure: CMS has temporarily waived the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which she/he is practicing for individuals; however, the following four conditions must be met:

- The provider must be enrolled as such in the Medicare program
- The provider must possess a valid license to practice in the State, which relates to his or her Medicare enrollment
- The provider is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity
- The provider is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area

This waiver does not have the effect of waiving State or local licensure requirements, or any requirement specified by the State or a local government, as a condition for waiving its licensure requirements.

V. BILLING AND CODING – MEDICARE

Disclaimer: The information provided is for medical coding guidance purposes only. It does not supersede or replace the AMA's Current Procedural Terminology (CPT®) manual, or other coding authority, constitute clinical advice, address or dictate payor coverage, or reimbursement policy. It is not a substitute for the professional judgement of the practitioner performing a procedure, who remains responsible for correct coding.

Medicare telehealth visits: Currently, Medicare patients may use telecommunication technology for office visits, hospital visits, and other services that generally occur in-person.

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. 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
- Covered telehealth services for PHE for the COVID-19 pandemic, effective 3/1/2020 CMS has expanded the approved list of telehealth codes to include more than 80 additional services furnished via telehealth. A list of all available codes for telehealth services can be found at the this link.

Virtual check-ins: Brief communication service with practitioners via several communication technology modalities, including synchronous discussion over a telephone or exchange of information through video or image, constitutes a virtual check-in. These virtual services will likely be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation. Virtual check-ins differ from Medicare telehealth visits in that they may be conducted with a broad range of communication methods.

The following codes may be used to bill for these services:

- HCPCS code G2012: Brief communication technology-based service, *e.g.*, virtual check-in by a physician or other qualified healthcare 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

Store and forward visits:

- 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: Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals and secured email.

Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) may 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, and clinical psychologists) may 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

Remote Patient Monitoring: Remote Patient Monitoring entails collecting and interpreting physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or qualified healthcare professional. Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. The following codes may be billed as appropriate:

- **99091**: Collection and interpretation of physiologic data (*e.g.*, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days
    - The provider receives an electronic communication containing physiologic data (*e.g.*, ECG result, blood pressures, or blood glucose test results) from a patient and/or the caregiver. They review the data and interprets the results, spending at least 30 minutes doing so each 30–day period
- **99457**: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
    - Do not report for services of less than 20 minutes
    - The provider evaluates recordings from remote monitoring equipment to track and report physiologic parameters such as weight, blood pressure, blood oxygen levels, and expiratory flow rate. The provider communicates with the patient or caregiver to adjust the patient's management based on the patient's reports. The provider can be clinical staff, physician, or other qualified healthcare provider, and this code represents the first 20 minutes of the provider's time

- 99458: Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes
    - Do not report for services of less than an additional increment of 20 minutes
    - The provider evaluates recordings from remote monitoring equipment to track and report physiologic parameters such as weight, blood pressure, blood oxygen levels, and expiratory flow rate. The provider communicates with the patient or caregiver to adjust the patient's management based on the patient's reports. The provider can be clinical staff, physician, or other qualified healthcare provider, and this code represents each additional 20 minutes of the provider's time
- 99473: Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration
    - The provider calibrates a home blood pressure monitoring device that has been validated for clinical accuracy and trains the patient on how to use it to monitor hypertension
    - Do not report more than once per device
- 99474: Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified healthcare professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient
    - The patient measures blood pressure using a validated blood pressure device, taking two readings one minute apart twice a day over a 30–day period. Takes a minimum of 12 readings and reports them to the provider. The provider collects the data, averages the systolic and diastolic blood pressures, prepares a report, and discusses a treatment plan with the patient.
    - Do not report more than once per calendar month
- 99453: Remote monitoring of physiologic parameter(s) (*e.g.*, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment
- 99454: Remote monitoring of physiologic parameter(s) (*e.g.*, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
    - Report once per episode of care
        - For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated and ends with attainment of targeted treatment goals
    - Do not report for monitoring of less than 16 days

Telephone services (audio only): Providers can now provide certain services by telephone during the COVID-19 PHE to both new and established patients.

Non-Face-to-Face Services – Telephone Services (Non-Physician)

Telephone evaluation and management service provided by a qualified non-physician healthcare professional 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. The following codes may be billed as appropriate:

- 98966: 5-10 minutes of medical discussion
- 98967: 11-20 minutes of medical discussion

- 98968: 21-30 minutes of medical discussion

Non-Face-to-Face Services – Telephone Services (Physician or Other Qualified Healthcare Professional)

Telephone evaluation and management service provided by a physician or other qualified healthcare 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. The following codes may be billed as appropriate:

- 99441: 5-10 minutes of medical discussion
- 99442: 11-20 minutes of medical discussion
- 99443: 21-30 minutes of medical discussion

Modifiers and Place of Service (POS): There is new guidance for usage of modifiers and POS when billing for non-traditional telehealth services for the duration of the Public Health Emergency.

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 non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the Public Health Emergency (PHE), bill with the Place of Service (POS) equal to what it would have been in the absence of a PHE for example POS 11, along with a 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 traditional telehealth services, there are two scenarios where modifiers are required, namely 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.

Documentation requirements: Code selection and documentation guidelines for office visits performed via telehealth will be based on physician time spent on the date of visit or medical decision-making (MDM).

Under the waiver issued by the Secretary pursuant to section 1135(b)(8) of the Act, telehealth office/outpatient E/M's can be furnished to any patient in their home regardless of their diagnosis or medical condition. However, the current E/M coding guidelines would preclude the billing practitioner from selecting the office/outpatient E/M code level based on time in circumstances where the practitioner is not engaged in counseling and/or care coordination.

On an interim basis, CMS is revising their 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.

VI. BILLING AND CODING – MEDICAID

Regulations regarding telehealth billing and coding for Medicaid beneficiaries vary by state and continue to evolve considering the current situation. Marwood recommends that providers refer to their state Medicaid site prior to providing telehealth services.

VII. BILLING AND CODING - COMMERCIAL

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Aetna (*last updated April 13, 2020*): From March 6, 2020 until June 4, 2020, Aetna will waive member cost sharing for a covered telemedicine visit regardless of diagnosis, for real-time virtual care delivered by an in-network provider. Aetna reimburses all providers for telemedicine at the same rate as in-person visits.

- Platforms Allowed:
    - Providers can temporarily use non-public-facing synchronous video chat platforms, such as Skype®, Zoom®, and FaceTime®, to complete telemedicine visits if these platforms are allowed in their states and they are able to meet the standard of care via a telehealth encounter. Healthcare providers should not, however, use public-facing video applications, such as Facebook Live®, Twitch®, or TikTok
- Delivery Method:
    - For the next 90 days, Aetna will cover minor acute evaluation and management care services rendered via telephone. A visual connection is not required. For general medicine and behavioral health visits, a synchronous audiovisual connection is still required
- Coding Guidance:
    - For the 90-day period, Aetna has added the following HCPCS codes below. All telemedicine services not noted will be covered according to Aetna's current policy
    - All other telemedicine coverage is stated in the Aetna Telemedicine policy which is available to providers on the NaviNet and Availity portals
- The following codes require an audiovisual connection:
    - G2061, G2062, G2063 – Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes; 11-20 minutes; or 21 or more minutes
    - 98970, 98971, 98972 – Qualified nonphysician healthcare professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes
    - 99421, 99422, 99423 – Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10; 11-20; or 21 or more minutes.
- The following codes require an audiovisual connection or telephone:
    - 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

- G2012 – Brief communication technology-based service, *e.g.*, virtual check-in, by a physician or other qualified healthcare 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
- 98966, 98967, 98968 – Telephone assessment and management service provided by a qualified nonphysician healthcare 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; 11-20; or 21-30 minutes of medical discussion
- 99441, 99442, 99443 – Telephone evaluation and management service by a physician or other qualified healthcare 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; 11-20; or 20-30 minutes of medical discussion

This link outlines approved behavioral health telemedicine services.

Care must be delivered by a physician, nurse practitioner (NP) or physician assistant (PA.)

Cigna (*last updated April 9, 2020*): Effective April 9, 2020 until at least May 31, 2020, members may use telemedicine services for any reason, not just COVID-19 diagnosis.

Coding Guidance:

- Cigna will allow providers to bill a standard face-to-face visit for all virtual care services, including those not related to COVID-19
  - Any service that is currently on a provider's fee schedule can be provided virtually. This means that if a provider has a code on their fee schedule today that is reimbursable, they can offer that same service virtually and bill Cigna using the same code (plus the GQ, GT, or 95 modifier), and be reimbursed the full face-to-face amount, at least until May 31, 2020
- Providers will be reimbursed in an amount consistent with their typical face-to-face rates
  - Care must be performed by a licensed provider, including mid-level practitioners, such as physician assistants and nurse practitioners
- Providers should use modifiers GQ, GT, or 95 to indicate virtual care for all services
- Providers should bill their standard face-to-face place of service for virtual care (*e.g.*, POS 11)
- For a virtual screening telephone consult (5-10 minutes), providers should:
  - Use code G2012
  - *Comments from Cigna:*
    - Effective through at least May 31, 2020
    - Must be performed by a licensed provider
    - Cost-share will be waived for all services (including non COVID-19 related services)
- For a non COVID-19 virtual visit (*i.e.*, telehealth), providers should:
  - Use the usual face-to-face E/M code
    - Append with GQ, GT, or 95 modifier
    - POS normally billed

- *Comments from Cigna:*
  - Exception during the Public Health Emergency
  - Effective through at least May 31, 2020
  - Cigna will reimburse usual face-to-face rates
  - Services can be performed by phone, video, or both
  - Standard cost-share will apply

Empire BlueCross BlueShield (New York only) (*last updated April 15, 2020*): Effective March 17, 2020, members may use telemedicine services for any reason, not just a COVID-19 diagnosis.

Delivery Method:

- Telemedicine (live video and audio via app):
  - This applies to Empire BCBS LiveHealth Online platform, as well as for care received from providers delivering virtual care through internet video and audio services
- Telehealth (telephonic with video capability)
- Telephonic-only care
  - Empire will cover telephonic-only visits with in-network providers where medically appropriate if all other requirements for a covered health service are met
  - This includes visits for medical services and behavioral health
  - Exceptions include chiropractic services, physical, occupational, and speech therapies. These services are not appropriate for telephone-only consultations
  - Phone delivery must be HIPAA compliant

Coding Guidance:

- For office visit telehealth, providers should:
  - Use the appropriate office visit E/M code (99201-99205; 99211-99215)
  - Use POS 02
  - Use modifier GT or 95 for commercial claims
- For audio-only, providers should:
  - Use the appropriate CPT code (99441, 99442, 99443, 98966, 98966)
  - POS would be the location where the provider initiates the call
  - No modifiers are required for commercial members

Care must be delivered by a physician, nurse practitioner (NP) or physician assistant (PA).

United Healthcare (*last updated April 14, 2020*): For dates of service March 18, 2020 until June 18, 2020, members may use telemedicine services for any reason, not just a COVID-19 diagnosis.

- United Healthcare will waive cost sharing for in-network telehealth services for medical, outpatient behavioral and PT/OT/ST services from March 31, 2020 until June 18, 2020
- For medical and outpatient behavioral telehealth visits, providers can utilize both interactive audio-video and audio-only
- For PT/OT/ST provider visits, interactive audio/video technology must be used
  - All visits must be performed using live videoconferencing that involves the presence of both parties at the same time and a communication link between them that allows a real-time audio and visual interaction to take place
  - Emailing “stored” exercise videos and discussing or reviewing by phone is not reimbursable

Platform Approved:

- Use of HIPAA-compliant or non-HIPAA-compliant audio-video or audio-only technology, such as FaceTime or Skype

Coding Guidance (Care must be delivered by a physician, nurse practitioner (NP) or physician assistant (PA)):

- For Audio-video or audio-only, providers should:
  - Use the appropriate office visit E/M code (99201-99205; 99211-99215)
  - Use POS that would have been reported had the service been provided in person
  - Use modifier 95 for commercial claims
- For E-Visits, providers should:
  - Use the appropriate CPT code (99421-99423)
  - Use appropriate HCPCS code (G2061-G2063)
  - Use POS that would have been reported had the service been provided in person
  - No modifiers are required for commercial members
- For E- Visits for non-qualified physician (physical, occupational, and/or speech therapist), providers should:
  - Use the appropriate HCPCS code (G2061-G2063)
  - Use appropriate place of service (11, 20, 22, 23)
  - No modifiers are required for commercial members
- For Virtual check-ins, providers should:
  - Use the appropriate HCPCS code (G2010; G2012)
  - Use the appropriate CPT codes (99441-99443 and 98966-98968)
  - Use POS that would have been reported had the service been provided in person
  - No modifiers are required for commercial members

VIII. KEY TAKEAWAYS AND CHANGES

Key Takeaways on Billing and Coding Medicare Telehealth Visits:

- Providers can render telehealth services to both new and established patients
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits
- Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings
- Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home

Key Takeaways on Billing and Coding Virtual Check-Ins:

- Providers can provide these services to both new and established patients
- The communication cannot be related to a medical visit within the previous 7 days, nor lead to a medical visit within the next 24 hours (or soonest appointment available)
- These services can be utilized in a variety of locales; they are not limited to only rural settings or certain locations
- Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement. The patient must verbally consent to receive virtual check-in services
- 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

Key Takeaways on Store and Forward Visits:

- Providers may provide these services to both new and established patients
- Providers should report on cumulative time for services once per 7-day period
- The code includes the sum of all communication related to the online encounter, such as phone calls, prescriptions, lab orders, and the like
- Providers should not report online digital E/M services for cumulative service time less than 5 minutes
- There are no geographic or location restrictions for these visits
- Patients can communicate with their doctors without going to the doctor's office by using online patient portals or secured email
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation

Key changes to the Medicare telehealth payment policies include:

- Effective March 1, 2020 and throughout the national Public Health Emergency, Medicare will pay physicians for telehealth services at the same rate as in-office visits for all diagnoses, not just for services related to COVID-19
- Office-based physicians should use their usual place-of-service (POS) code to be paid at the non-facility rate for telehealth services and add modifier 95 to telehealth claim lines. Telehealth services billed using POS code 02 (telehealth) will be paid at the facility rate
- Physicians can reduce or waive Medicare patient cost-sharing for telehealth visits, virtual check-ins, e-visits, and remote monitoring services

Key changes to expanded accessibility of telehealth include:

- Patients in all settings – including in their home – and across the entire country, not just in rural areas, may receive telehealth services
- Physicians may provide telehealth services to both new and established Medicare patients
- Consent for telehealth services may be obtained by staff or the practitioner at any time, and is required only once on an annual basis
- Physicians may provide telehealth services from their home
- Physicians licensed in one state may provide services to Medicare beneficiaries in another state. However, state licensure laws still apply

Key changes to the expansion of telehealth services include:

- Physicians may now provide audio-only telephone evaluation and management visits for new and established patients
- Physicians may now provide more services to beneficiaries via telehealth. The services can be provided to either new or established patients
- CMS removed frequency limitations on several Medicare telehealth services
- Physicians can provide remote patient monitoring (RPM) services to both new and established patients for both acute and chronic conditions and for patients with only one disease
- Practitioners, such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists, will have expanded access to telehealth, virtual check-ins, e-visits, and telephone calls during the crisis
- The U.S. Drug Enforcement Administration (DEA) will permit physicians to prescribe controlled substances based on telehealth visits during the pandemic. State laws apply

Key changes to the compliance policies include:

- HHS will not conduct audits to ensure that a prior patient relationship existed for claims submitted during this public health emergency
- Physicians don't have to use fancy technology; any two-way audio-visual device will do, such as Facetime, Skype, or Zoom. However, the Office for Civil Rights (OCR), which enforces HIPAA, has stated that physicians should not use Facebook Live, Twitch, TikTok, or other public facing communication services
- OCR announced that it will use its enforcement discretion for physicians using telehealth, so that if they do not have time to conduct a security risk analysis or enter into a business associate agreement (BAA), they can still use telehealth to see patients during the crisis without fear of HIPAA penalties
- The OCR guidance emphasized that physicians are encouraged, but not required, to notify patients of the potential security risks of using these services and to seek additional privacy protections by entering into business associate agreements (BAAs)

IX. CONCLUSION

CMS and the federal government have lifted many restrictions on the use of telemedicine to reduce regulatory burdens on physicians during the COVID-19 pandemic. Many of these waivers affect the payment, accessibility, expansion of services, and compliance policies of the telemedicine sector.

About the Author

David Alben is a senior member of the Marwood team and leads the Clinical Compliance practice. Before to joining the Marwood Group, he served as a Founder/Principal Consultant at Genco Healthcare Management where he focused on Regulatory Compliance, Business Process Improvement, RCM/Medical Billing and Collections, and Credentialing and Contract negotiations. Prior to his tenure at Genco Healthcare Management, Mr. Alben held senior positions at two publicly traded healthcare companies. As an entrepreneur, he built and successfully operated a number of healthcare companies in the Medicare Part B space

Marwood Group is a healthcare advisory firm offering strategic consulting services, with expertise in assessing how well a Company operates from a clinical quality and compliance perspective, assessing risks and providing advice on areas in need of improvement

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