Subject: **Updates** to Medicare & Medicaid COVID-19 Telemedicine Payment Waivers

Effective Date: March 1, 2020

Source Authority

- **New** Interim Final Rule - Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program
- Interim Final Rule - Medicare and Medicaid Programs, Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (PHE)
- **Updated** Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
- **Updated** List of Medicare Telehealth Services
- **Updated** Latest & Greatest Tables (attached PDF)
- **Updated** FAQ - Medicare & Medicaid COVID-19 Telemedicine Payment Waivers (attached PDF)
- **Updated** Summary - Medicare & Medicaid COVID-19 Telemedicine Payment Waivers (attached PDF)

Background: The Centers for Medicare and Medicaid Services (CMS) recognizes the importance of a beneficiary's ability to receive care in their home during the Public Health Emergency (PHE). It has adopted broader flexibilities in providing services using remote communications technology to avoid exposure risks to healthcare providers, patients and the community. Telehealth, telemedicine and related terms generally refer to the exchange of medical information from one site to another through electronic communications.

The following types of telemedicine services may be provided to Medicare & Medicaid beneficiaries:

- **Telehealth:** Audio and video equipment permitting two-way, real-time interactive communication
- **Virtual Check-Ins:** Patient initiated communication via telephone/other device or remote evaluation of recorded video/images submitted by the patient
- **E-Visits:** Patient initiated communication through an online patient portal
- **Telephone Services**: Evaluation & Management (E&M) services for audio-only devices

Summary of Updates: The new Interim Final Rule published on April 21, 2020 significantly expanded coverage, coding and billing guidance for Telehealth services.

- **Expansion of Telehealth Services**: CMS has added 135 CPT codes to the List of Medicare Telehealth Services that can be provided via Telehealth during the PHE. Refer to Table 1 for list of expanded services.
- **Audio-Only Telehealth for Certain Services**: CMS updated the list to allow 87 services that can be provided by audio-only, including Annual Wellness Visits (AWV). Refer to Table 8 for the list of specific services.
- **Eligible Practitioners**: CMS waived the eligible practitioner requirements for Telehealth services to allow all provider types eligible to bill Medicare for their services, including physical therapists, occupational therapists, speech language pathologists (PT, OT, SLP).
- **Hospital Outpatient Departments:** CMS has clarified that they will pay for hospital ***therapeutic services*** provided to a patient located in their home.
    - ***Therapeutic services*** are placed in to three categories:
        - outpatient therapy, education and training;
        - clinical staff services; and
        - hospital services delivered by Telehealth.
    - PO Modifier required to be reported on the claim in addition to modifier 95
- **Telephone E&M Services**: CMS updated the list to recognize certain Telephone E&M services as a Telehealth service. As a result, these Telephone E&M visits will be paid at the Office/Outpatient E&M rates.

- **Hospital Charges & Professional Telehealth Services**: When the patient or the provider are located in their home, the hospital should continue to report the facility charge on the UB.
- **Office/Outpatient E&M Level of Service Based on Time**: CMS changed their guidance and are now recognizing the CPT time definition. Please note, the counseling statement is still not necessary.
- **Out of State Telehealth**: Licensure waivers granted by CMS does not also waive individual state licensure requirements. Those requirements would continue to apply unless waived by the state. Refer to Table 9 for to-date licensure requirements for each state during the PHE.
- **Remote Physiologic Monitoring**: For patients with suspected or confirmed COVID-19 diagnosis, the minimum days have been reduced to allow at least 2 days. Previously, monitoring that lasted less than 16 days were not eligible to be reported. **This only applies to patients with suspected or confirmed COVID-19 diagnosis.**

Telehealth

- **Expanded Coverage**
  - **Services: New services added to the list (Table 1)**
  - **Services: Audio-Only Telehealth for certain services (Table 8)**
    - **Examples: Annual Wellness Visit (AWV), Advance Care Planning, Diabetes Self-Management and Intensive Behavioral Counseling**
  - **Patient Location**: Any type of healthcare facility or their home located in all areas (not just rural)
  - **Patient Relationship**: New or Established
  - **Provider Location**: Temporary location, e.g. home
  - **Provided By**: Expanded to allow all provider types that are eligible to bill Medicare for their services, includes therapy services provided by PT, OT, and SLP practitioners
  - **Facility Charge**: Deaconess Hospital will be able to bill for the facility charge for patients or providers located in their home during the PHE
- **Consent**: Specific consent for Telehealth visits are not required. Follow established consenting processes.
- **Face-to-Face/Hands-On Visits Can Be Provided Via Telehealth**
  - ESRD Services: 90951-90955, 90957-90970
  - Initial Nursing Home/Skilled Nursing Facility (SNF) Visits: 99304-99306
  - Initial Home Health Certification
- **Removal of Frequency Requirements for Inpatient, Nursing Facility and Critical Care Via Telehealth**
- **Expanded Definition of Homebound Status for Medicare Home Health Benefit**
  - Includes if medically contraindicated to leave the home due to confirmed or suspected diagnosis of COVID-19 **or** has a condition that may make the patient more susceptible to contracting COVID-19
  - Exercising self-quarantine is not considered “confined to the home” unless the physician certifies that it is medically contraindicated for the patient to leave the home
  - Even if the patient meets the definition, they must still require skilled care. The collection of a specimen at home is not considered skilled care.
- **Documentation Requirements for Office/Outpatient E&M Services (Table 2)**
  - Level of service can be based on Medical Decision Making (MDM) or Time
    - Time defined as the total time personally spent on the day of the visit, which includes face-to-face and non face-to-face time. **Typical times found in the CPT Manual for Office/Outpatient E&M Services**.
    - Requirements to document History & Exam have been removed
    - Only applies to office/outpatient visits conducted via Telehealth

Virtual Check-Ins & E-Visits (Tables 4-6)

- **Virtual Check-Ins (G2010 & G2012), E-Visits (99421-99423, G2061-G2063): Patient Initiated**
- **Remote Physiologic Monitoring (99091, 99453-99458)**
- **Expanded Coverage**
  - **Patient Location**: Located in all areas (not just rural)
  - **Patient Relationship**: New or Established
  - **Patient Condition(s)**: Acute or Chronic
- **Minimum Days for Remote Monitoring**
  - **Acute or Chronic Conditions**: Require a minimum of 16 days
  - **Suspected or Confirmed COVID-19**: Reduced from 16 to a minimum of 2 days
- **Provided By**
  - G2010-G2012: Physicians & Non-physician Practitioners (NPP)
  - 99421-99423: Physicians & Non-physician Practitioners (NPP)
  - G2061-G2063: Non-physician healthcare professionals (e.g. PT/OT/SLP, licensed clinical social workers, clinical psychologists)
- **Consent**: Obtained annually or at time of visit by either the provider or other staff (verbal)
- **Technology**: Unlike Telehealth services, may be conducted with a broader range of communication methods and **does not** require both interactive audio and video telecommunications system
- **Coding Rules**: Cannot be reported when an E&M service was provided in the past 7 days or leads to another service within 24 hours or soonest appointment, including a Telehealth visit.

Telephone E&M Services (Table 7)

- **New Medicare & Medicaid Coverage**
- **Patient Relationship**: New or Established
- **Who Can Provide**
  - 99441-99443: Physicians & Non-physician Practitioners (NPP)
  - 98966-98968: Non-physician healthcare professionals (e.g. PT/OT/SLP, licensed clinical social workers, clinical psychologists)
- **Telehealth**: CPT 99441-99443 are now recognized as Telehealth services
- **Payment**: CPT 99441-99443 will be reimbursed as if they were an office E&M service
- **Consent**: Obtained annually or at time of visit by either the provider or other staff (verbal)
- **Coding Rules**: Cannot be reported when an E&M service was provided in the past 7 days or leads to another service within 24 hours or soonest appointment, including a Telehealth visit.

Summary: The expanded coverage will be in effect until the PHE declared by the Secretary of HHS and the Governor's Executive Order ends. These flexibilities will help us offer medical services to patients remotely so that our emergency departments and doctor's offices are available to deal with the most urgent cases and reduce the risk of additional infections.

This Latest & Greatest communication has been developed to assist you with understanding and implementing the expanded coverage of telemedicine services for Medicare and Medicaid beneficiaries during the PHE. Please contact Sarah Compton, Telehealth Program Coordinator, for assistance with implementation.