TELEHEALTH TOOLKIT DURING THE COVID-19 RESPONSE: NEW OPTIONS FOR PATIENT ACCESS AND OUTREACH

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The U.S. Department of Health and Human Services (HHS) has issued several waivers applicable to the provision of telehealth services during the COVID-19 emergency period. Some of these waivers expand Medicare coverage and help ease regulatory burdens so patients and providers can exchange information through electronic communications, with a focus on helping patients communicate with their providers from home. At the state level, governors, state medical boards, and public health and Medicaid agencies are working to remove regulatory burdens to swift disaster response. This alert compiles some of these resources to help clients understand the current and fluid environment for expanding telehealth communications with patients during the COVID-19 nationwide public health emergency ("response period").

CMS AND HEALTH PLAN WAIVERS

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) issued a waiver broadening access to traditional telehealth services so that program beneficiaries can receive telehealth services from their healthcare providers without having to travel to a healthcare facility. CMS has given states broad flexibility to reimburse providers for telehealth services under state Medicaid and Children's Health Insurance Programs (CHIP) and is ***not requiring federal approval*** for states to cover telehealth services in the same manner or at the same rate as face-to-face services. CMS is providing states with ***policy options*** for further flexibility and is rapidly approving Medicaid waivers from state agencies. Coverage varies, so state waivers should be consulted for differing coverage conditions. CMS also issued waivers permitting Medicare Advantage Organizations to waive requirements, so stay tuned to further announcements from the health plans in your area. The American Association of Health Plans has compiled a list of actions that commercial, Medicaid, and Medicare ***managed care providers*** are taking.

MEDICARE TELEHEALTH OVERVIEW

The Coronavirus Preparedness and Response Supplemental Appropriations Act (Coronavirus Response Act), signed into law by President Donald Trump on March 6, 2020, includes a provision allowing the Secretary of HHS to waive certain Medicare telehealth payment requirements during a public health emergency. CMS issued a ***waiver and related guidance*** shortly thereafter. The waiver, which is effective for services provided on or after March 6, 2020, allows Medicare beneficiaries in all areas of the country to receive telehealth services, including at home. The waiver permits a range of providers, including physicians, nurse practitioners, clinical psychologists and licensed clinical social workers, to offer telehealth services to their patients. A summary of CMS' changes to Medicare telehealth coverage under the Coronavirus Response Act can be found in the following chart.

TRADITIONAL MEDICARE-COVERED COMMUNICATIONS-BASED TECHNOLOGY SERVICES

DURING COVID-19 WAIVER PERIOD

Type of Service	Technology System	Service	Examples with short HCPCS/CPT Code Description	Patient Relationship
Telehealth Visits	Audio/visual with 2-way, real-time interaction; includes smart phone and video chat	Visit with physician or eligible practitioner (such as MDs, NPs, PAs, CRNAs, psychologists, etc.) at distant site using telecommunications systems; patient can be at any U.S. location until emergency ends	• 99201-15 Office and other OP visits • G0425-G0427 Telehealth consults, ED/ initial hospital visit • G0406-G0408 Follow up IP telehealth consult; patient in hospital or SNF • Professional Consults • Office Psychiatry Services • Annual Wellness	New* or established *CMS declines to audit prior relationships for services during public health emergency
Virtual Check-ins	Phone call or smart phone encounter	Patient initiates phone or video chat check-in for triage to rule out office visit, synchronous (bundled if subsequent office visit within 24 hours) Qualified provider (licensed and appropriately credentialed) remotely interprets and responds within 24 business hours to patient-submitted video and/or images, asynchronous	• HCPCS G2012 Brief (5-10 min.) patient-initiated check-in with practitioner via phone or other telecom device to decide whether office visit or other service needed • HCPCS G2010 Remote evaluation of recorded video and/or images submitted by an established patient	Established patients within the practice billing Medicare in past three (3) years
E-Visits	Electronic messaging (e.g., via EHR patient portal)	Patient initiates communication to eligible provider (such as MDs, physical therapists, clinical psychologists, etc.) via online patient portal, providers may alert patients to availability (e.g., COVID-19 symptom questionnaire)	• 99421-99423 Digital E/M, time-based (e.g., 5-10 minutes) • G2061-G2063 Qualified non-physician healthcare professional online assessment, time-based	Established patients within the practice billing Medicare in past three (3) years

3/17/2020: Medicare Telemedicine Health Care Provider Fact Sheet, CMS.GOV.

These services are described by HCPCS codes and paid under the Medicare Physician Fee Schedule. CMS' waiver allows these services to be provided to patients by eligible professionals regardless of the patient's location. Although generally, Medicare coinsurance and deductibles apply, please refer to the section below titled ***OIG – Reductions or Waivers of Cost-Sharing Obligations***. CMS' guidance on Medicare telehealth services under the Coronavirus Response Act (CMS Telehealth Guidance) describes three types of services covered by the waiver: Medicare Telehealth Visits, Virtual Check-ins, and E-Visits.

MEDICARE TELEHEALTH VISITS

MEDICARE FFS TELEHEALTH VISIT COVERAGE UNDER CORONAVIRUS RESPONSE ACT (CRA)

- **Interactive Communications** System with AV for 2-way, real-time interactive communication between patient and eligible practitioner
  - Now includes phone with AV capabilities used for 2-way interaction, such as smart phones and video chats
- **Originating site**: patient located at certain provider sites (e.g., physician, hospital, RHC, FQHC, SNF) and limited in-home purposes (ESRD, SUD, mobile stroke) in Health Professional Shortage Area (HPSA) or Rural HPSA county, with exceptions
  - Now includes all U.S. locations, including patient homes, until national emergency state ends
- **Distant site eligible physician or practitioner** (PA, NP, CNS, CRNA, Nurse-Midwife, CSW, RD, Clinical Psychologist) licensed to furnish telehealth under state law
  - Now includes physicians and practitioners who furnished Medicare telehealth service to patient within last 3 years, or in same practice as such provider (HHS will not audit this prior relationship requirement under 1135 Waiver)
- Services must still be medically appropriate
  - Medical exam under control of physician or practitioner control at distant site
  - Tele-presenter not required with patient unless medically necessary
- Services provided must be provided by providers and practitioners authorized to bill
  - Office or other outpatient visits
  - Professional consultations
  - Office psychiatry services
  - Annual wellness visits
  - Obesity counseling
  - Smoking cessation
  - ESRD in home dialysis
- Medicare pays 80% of Physician Fee Schedule for distant site practitioner telehealth services
  - No originating site facility fee in home
- Check state orders waiving license requirements for out-of-state physicians and other practitioners

Source: 3.16.20: Medicare Telehealth Benefit, 42 C.F.R. 410.78, in Light of Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 ("Coronavirus Response Act") in Telehealth Services During Emergency Periods Act of 2020

Medicare telehealth visits require the use of interactive audio and video telecommunications systems to permit real-time communication between a distant site and the patient, including smart phone and video chat during the waiver period. Distant site practitioners can include physicians, nurse practitioners, physician assistants, nurse midwives, CRNAs, clinical psychologists, clinical social workers, registered dietitians and nutrition professionals. CMS maintains a list of services that are normally furnished in-person that may be furnished via telehealth. This list is available ***here***. During the public health emergency, these visits are considered the same as an in-person visit and paid at the same rate as regular in-person visits. *These services can be provided to any Medicare beneficiary, including in situations where the provider and beneficiary have not had a prior existing relationship.* The CMS Telehealth Guidance is clear that HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

In a related move, the DEA will now ***permit DEA-registered practitioners*** providing telehealth visits to prescribe Schedule II-V controlled substances for a legitimate medical purpose to patients for whom they have not conducted an in-person medical evaluation. The practitioner must otherwise act in compliance with federal and state laws, including the DEA regulations for electronic prescribing or calling the pharmacy for Schedule III-V prescription and, in medical emergencies, calling in Schedule II prescriptions.

VIRTUAL CHECK-INS

Virtual check-ins allow established Medicare patients in their home to have a brief communication with a practitioner via a telephone or exchange of information through video or image. CMS expects these virtual services to be initiated by patients; however, practitioners may need to educate patients on the availability of the service prior to patient initiation. The virtual check-ins are for patients with an established relationship with the provider where the communication is not related to a medical visit within the previous seven days and does not lead to a medical visit within the next 24 hours. Patients verbally must consent to receive the services, and the Medicare coinsurance and deductibles will apply. CMS provides the following billing guidance for these services: *Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient's concern by telephone, audio/video, secure text messaging, email or use of a patient portal. Standard Part B cost sharing applies to both. In addition, separate from these virtual check-in services, captured video or images can be sent to a physician (HCPSC code G2010).*

E-VISITS

Established 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. These services can only be reported when the billing practice has an *established relationship with the patient*. The patient must generally initiate the initial inquiry, and communications can occur over a seven-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. Patients verbally must consent to receive the services, and the Medicare coinsurance and deductibles will apply.

MEDICARE-COVERED TELEHEALTH VIRTUAL CHECK-INS AND E-VISITS – ESTABLISHED PATIENTS ONLY

Virtual Check-ins

- Video or image virtual check-in (HCPCS G2010)
  - Short, patient-initiated communications with a healthcare provider
  - Remote evaluation of recorded video and/or images submitted by an established patient, including interpretation with follow-up with patient within 24 business hours, not originating from a related E/M service provided within previous 7 days nor leading to an E/M service or procedure within next 24 hours or soonest available appointment
- Telephone virtual check-in (HCPCS 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 previous 7 days nor leading to an E/M service or procedure within next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

E-Visits

- E-Visits are non-face-to-face patient-initiated communications through online patient portal
- Online patient portals (HCPCS 2061)
  - Qualified nonphysician healthcare professional online assessment, for an established patient, up to 7 days, cumulative time during the 7 days; 5-10 minutes
- Online patient portals (CPT 99421-99423)
  - Online digital E/M service, established patient, up to 7 days cumulative time during the 7 days; 5-10 minutes (99421); 11-20 minutes (99422); 21 or more minutes (99423)

Source: 3.16.20: 2020 CPT® codes 99421-99423 in CPT Book. CMS HCPCS Codes. 3.17.20: Medicare Telemedicine Health Care Provider Fact Sheet, CMS.GOV

STATE LICENSING WAIVERS

The CMS Telehealth Guidance does not waive out-of-state healthcare provider licensure requirements, but noted that it would temporarily waive in-state licensure payment conditions for providers licensed in other states. With that said, many states have begun to either fast track the temporary licensing of out-of-state physicians and other practitioners or to recognize unrestricted out-of-state licenses to practice within that scope as sufficient during the pendency of the order. The Federation of State Medical Boards (FSMB) has compiled a list of ***links to emergency orders*** by governors and state agencies.

OIG – REDUCTIONS OR WAIVERS OF COST-SHARING OBLIGATIONS

The HHS Office of Inspector General (OIG) has issued a policy statement to notify healthcare providers that they will not be subject to administrative sanctions for reducing or waiving any cost-sharing obligations federal healthcare program beneficiaries may owe for certain telehealth services, subject to the conditions specified in the policy statement. The policy statement can be accessed ***here***. OIG clarified in ***FAQs*** on March 24, 2020, that the policy statement applies to the broader category of telehealth services in the first chart above, as well as monthly remote patient monitoring and chronic care management services.

Routine reductions or waivers of costs owed by federal healthcare program beneficiaries, including cost-sharing amounts such as coinsurance and deductibles, potentially implicate the federal Anti-Kickback Statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries. Nonetheless, recognizing the unique circumstances resulting from the COVID-19 outbreak, the OIG will not subject physicians and other practitioners to OIG administrative sanctions for arrangements that satisfy *both* of the following conditions:

1. A physician or other practitioner reduces or waives cost-sharing obligations (i.e., coinsurance and deductibles) that a beneficiary may owe for telehealth services furnished consistent with then-applicable coverage and payment rules. The policy statement also applies to hospitals and other eligible entities operating under a reassignment of Medicare benefits from the physician or other practitioner.

2. The telehealth services are furnished during the time period subject to the COVID-19 public health emergency declaration (the "COVID-19 Declaration").

The policy statement is subject to the following additional considerations:

- Nothing in the policy statement requires physicians or other practitioners to reduce or waive any cost-sharing obligations federal healthcare program beneficiaries may owe for telehealth services during the time period specified in condition 2 above.
- For any free telehealth services furnished during the time period subject to the COVID-19 Declaration, the OIG will not view the provision of free telehealth services alone to be an inducement or as likely to influence future referrals (i.e., OIG will not view the furnishing of subsequent services occurring as a result of the free telehealth services, without more, as evidence of an inducement).
- Nothing in the policy statement will affect the operation of CMS's programmatic rules and regulations.
- Nothing in the policy statement otherwise affects a physician's or other practitioner's responsibility to bill only for services performed and to comply with legal authorities related to proper billing, claims submission, cost reporting, or related conduct.
- Nothing in the policy statement affects a physician's or other practitioner's responsibility to comply with federal, state, or local statutes, rules, regulations, ordinances, or other laws that may be applicable and in effect at the time.

The OIG has specifically reserved the right to reconsider the issues raised in the policy statement and to modify or terminate the policy statement at any time.

RELATED HIPAA AND PART 2 GUIDANCE DURING THE EMERGENCY WAIVER PERIOD

The HHS Office for Civil Rights (OCR) initially had issued a ***bulletin*** making clear that, even in emergency situations such as the COVID-19 outbreak, the protections of the HIPAA privacy rule still apply. OCR issued a ***limited waiver*** of certain HIPAA privacy requirements strictly for hospitals, but that waiver applies only during the first 72 hours of a hospital's implementation of a disaster protocol.

OCR WAIVER OF GOOD FAITH TELEHEALTH UNDER HIPAA PRIVACY AND SECURITY RULES

On March 17, ***OCR announced*** that it will exercise its enforcement discretion for healthcare providers that are covered entities under HIPAA that use audio or video communication technology to provide telehealth during the COVID-19 response period. OCR issued further ***guidance on telehealth remote communications*** in the form of FAQs. In that guidance, OCR provided a very broad definition of telehealth services not limited by any payment or coverage restrictions imposed by third-party payors and Medicare or Medicaid. OCR states that it will use enforcement discretion and not impose penalties for HIPAA violations by healthcare providers acting in good faith to provide telehealth during the COVID-19 nationwide emergency. This provision means that providers may use video chat apps (e.g., such as FaceTime, Skype, Facebook Messenger, and Google Hangouts) regardless of whether the service relates to the diagnosis and treatment of conditions related to COVID-19 (e.g., sprained ankles and other covered medical conditions). Other technologies that are public facing, such as Facebook Live, Twitch, and TikTok, should not be used to provide telehealth services.

OCR also will not impose penalties on providers using a video communication technology in good faith from a vendor that does not offer HIPAA business associate agreements (BAA). Note that more vendors with video communication products are beginning to offer their solutions under a HIPAA BAA model that tracks the HIPAA Security Standards, and this market is likely to expand rapidly.

Providers will be expected to use encryption where the technology permits, and if using an unsecure technology, to notify patients of the privacy and security risks associated with the use of such technology. Providers should consider the impact that technology changes and remote working conditions have on the security and stability of their network, and when considering changes during the response period, update their security risk assessments for these additional threats, vulnerabilities, and safeguards accordingly.

OCR also provided examples of what it considers the bad faith provision of telehealth services that would not be subject to enforcement discretion. Those examples include using public-facing products, conducting criminal acts (e.g., intentional invasion of privacy, fraud or identity theft), and further using or disclosing the information from a telehealth service improperly by selling it or using it for marketing purposes without authorization.

SAMHSA PART 2 GUIDANCE

The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) issued ***COVID-19 guidance for federal Part 2*** Substance Use Disorder (SUD) programs as many SUD clinics may be shut down and their patients unable to provide in-person consent. Under the medical emergency exception, providers can use their professional judgment to determine whether a bona fide medical emergency exists. When the patient's prior informed consent cannot be obtained, the SUD program provider may disclose SUD records to other medical personnel without consent as necessary to meet the medical emergency and document the disclosure after it is made. The medical personnel treating and receiving SUD information for the medical emergency may re-disclose the information for treatment purposes as needed.

Note that these waivers do not waive state law restrictions that are more stringent than HIPAA. Questions regarding whether a specific disclosure is permitted under HIPAA or whether applicable state law restrictions preempt HIPAA should be directed to legal counsel.

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