Telehealth Toolkit for Providers

Background

In order to respond to the need to limit the community spread of COVID-19, the Centers for Medicare and Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a health care facility. CMS is expanding this 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 the broader effort by CMS and the White House Coronavirus Task Force to ensure that all Americans – particularly those at high-risk of complications from the virus that causes the disease 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.

Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places 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 to their patients. Additionally, the 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.

Medicare Telehealth Visit Guidance

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.
    - These visits are considered the same as in-person visits and are paid at the facility rate for in-person visits.
- While the Medicare telehealth requirement generally requires a patient to travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for telehealth services furnished to beneficiaries in any healthcare facility and in their home in all areas of the country.
- Physicians can provide telehealth services from their homes. It is not necessary for physicians to update their Medicare enrollment file with their home address.
- To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Coinsurance

The Medicare coinsurance and deductible would generally apply to telehealth services. However, the HHS OIG is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs. OIG's statement on this can be found here, as well as their telehealth factsheet.

Licensure Requirements

- If you are licensed in the state where the patient is located, there are no additional requirements.
- If you are not licensed in the state where the patient is located:
    - CMS has issued the following waiver for Medicare patients: Temporarily waive requirements that out-of-state providers be licensed in the state where they are providing services when they are licensed in another state. Physicians are still bound by their state licensing requirements. Medicaid waivers must be requested by the individual state that wants to use them.
    - Many states have temporarily relaxed licensure requirements related to physicians licensed in another state and retired or clinically inactive physicians. This includes waiving licensure requirements or offering a temporary expedited license for out-of-state physicians. Many, but not all of these measures apply to physicians providing telemedicine across state lines. Please contact your state board of medicine or department of health for up-to-the minute information.
    - The Federation of State Medical Boards (FSMB) is tracking executive orders related to licensure.

Direct Supervision Requirements

For services requiring direct supervision by a practitioner or teaching physician, the physician supervision can be provided virtually using real-time audio/video technology. For allergy services specifically, direct supervision is required for testing (95004, 95024, 95027) and vial preparation (95165). During the public health emergency, the direct supervision by the physician can be provided virtually with real audio/video technology.

Telehealth Technological Requirements

Visits can be performed using any device with audio and video capabilities. Medicare generally requires telehealth services to be provided through HIPAA compliant software. However, the Office of Civil Rights (OCR) is exercising enforcement and waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the public health emergency. More information on this can be found here.

Medicare Recommendations for Reporting Virtual Visits

Type of Service	Description	HCPCS/CPT Code	Patient/Provider Relationship
Medicare Telehealth Visits	A visit with a provider that uses **two-way, interactive audio/video telecommunication** systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial outpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new and established patients
Virtual Check-in	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	G2012 G2010	For new and established patients
E-visits	A communication between a patient and their provider through an online patient portal.	99421 99422 99423 G2061 G2062 G2063	For established patients
Telephone Visits	A communication between a patient and their provider by telephone (audio) only. These are similar to virtual check-ins.	98966 99867 99868 99441 99442 99443	For new and established patients
Remote Physiologic Monitoring (RPM)	A communication technology-based service (CTBS) between a patient and a provider used for physiologic monitoring of	99091 99453 99454 99457 99458	For new and established patients

	patients with acute and/or chronic conditions.	99473 99474	

Telehealth Coding Guidance

Medicare telehealth services should be reported with the place of service (POS) code that would have been reported had the service been furnished in person. For example, POS code 11 should be reported for services that would have been delivered in the physician office. These claims should be flagged with the modifier code 95. Check with insurers for their requirements for reporting telehealth claims.

E/M Documentation Requirements

CMS has relaxed the documentation requirements for virtual visits during the public health emergency. Similar to in-person visits, documentation for virtual visits should meet billing criteria for new and established patient codes. Providers should indicate that the visit was conducted using a two-way audio-visual device. There is no requirement that the visit be recorded or stored for later access.

The policy allows office/outpatient E/M level selection (99201-99205, 99211-99215) when furnished via telehealth to be documented based on medical decision-making (MDM) or time, using the current definitions of MDM and time. Documentation of the patient's history and/or physical exam in the medical record is not required. However, the provider should document E/M visits as necessary to ensure the continuity of care.

Billing for Audio-only Calls

Providers can evaluate new and established Medicare beneficiaries with care by telephone only through several options:

- Virtual check-ins (CPT codes G2010, G2012)
- Telephone assessment and management service provided a qualified nonphysician health care professional (CPT codes 98966-98968)
- There are six telephone evaluation and management (E/M) services, three for qualified health professionals (CPT codes 98966-98968) and three for physicians (CPT codes 99441-99443) by a physician or other qualified health care professional (CPT codes 99441-99443). **NOTE: These visits are more like virtual check-ins, like outpatient E/M services.** They can be billed if the following criteria are met:
    - The visit cannot originate 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 codes are reported based on the time spent speaking with the patient.

Length of phone call	Code
5-10 minutes	99441/98966
11-20 minutes	99442/98967
21-30 minutes	99443/98968

Useful Resources

- CMS General Provider Telehealth and Telemedicine Tool Kit: https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
- AMA Telehealth Implementation Playbook: https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf