

# TELEHEALTH AND COVID-19

Friday, April 3, 2020

2:00 PM ET / 1:00 PM CT / 11:00 AM PT

# Disclaimer

- The speakers represent hospitals and hospital systems, physicians and other healthcare professionals, trade associations, long-term care facilities, home health agencies, pharmacies, managed care organizations and related entities
- This presentation is not to be construed as or relied upon as legal advice

# AGENDA

- Introduction
- Legislative Overview
- Telehealth Reimbursement and Billing
- State Licensure
- Federal Waivers Related to Telehealth
- 340B Patient Definition
- Questions

# LEGISLATIVE OVERVIEW

## PEGGY TIGHE

# Legislative Overview

- EMERGENCY SUPPLEMENTAL – PHASE 1

**Signed into Law on March 6**

- “The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020” (H.R. 6074)
- \$8.3 BILLION emergency funding
- Significant funding to HHS to treat and stop the spread of COVID19
  - Vaccines and testing kits for local communities
  - State and local health departments staffing increases and additional laboratory equipment
  - Federal government funding to aid in international containment
  - **TELEHEALTH: Expands telehealth in emergency areas to patients in their homes**
  - And much more...

<https://www.powerslaw.com/legislative-memorandum-on-covid-19/>

# Legislative Overview (cont'd)

- EMERGENCY SUPPLEMENTAL – PHASE 2

**Signed into Law on March 18**

- Families First Coronavirus Response Act (H.R. 6201)
- \$1 TRILLION
- Targeted relief for both individuals and businesses.
  - Expansion of coverage for COVID-19 testing
  - Paid sick leave
  - Insurance coverage of coronavirus testing
  - Nutrition assistance
  - Unemployment benefits
  - **TELEHEALTH: Technical clarifications to first package's telehealth waiver**
  - And much more...

# Legislative Overview (cont'd)

- EMERGENCY SUPPLEMENTAL – PHASE 3

**Signed into Law on March 27**

- The Coronavirus Aid, Relief, and Economic Security (CARES) Act
- \$2 TRILLION (largest ever for U.S.)
- Targeted, additional funding to workers, small businesses and industries impacted by economic downturn.
  - Higher unemployment benefits to individuals; individual rebates for certain taxpayers
  - Business tax credits for keeping workers on payrolls and refunds
  - State and local government funding & loans to airlines and other businesses
  - \$100m in hospital funding grants
  - **TELEHEALTH: Technical clarifications to first package's telehealth waiver, including corrections to expand to FQHCs**
  - And much more...

**[POWERS COVID PHASE 3 SUMMARY](#)**

# Legislative Overview (cont'd)

## EMERGENCY SUPPLEMENTAL BILLS – GOING FORWARD

- Democrats
  - Seeking additional funding for state and local governments to address the rapidly spreading virus
  - Expanding the pool of people who qualify for family and medical leave
  - More federal dollars for food aid
  - Stronger worker protections for first responders
  - Funding to offset coronavirus treatment costs
  - Stabilizing pensions
  - May include telehealth corrections/expansions



# Legislative Overview (cont'd)

- Republicans
  - Senate Majority Leader Mitch McConnell (R-KY): “We may need a 'phase four,' but we're not even fully into 'phase three' yet.”
  - Senator Rob Portman (R-OH): “It’s fine to start talking about it, but it’s not going to be effective until we have the health care crisis under control...”
  - Sen. Pat Toomey (R-PA): “Before we jump into another massive bill, let’s take a deep breath,” but he added that Congress would “probably” need to pass legislation to fix issues at some point.

Powers COVID-19 Resources Page

<https://www.powerslaw.com/covid-19/>

# TELEHEALTH REIMBURSEMENT AND BILLING

## REBECCA BURKE

# COVID-19 Supplemental: Phase 1

- H.R. 6074 was signed into law by the President on March 6, 2020. The bill provides \$8.3 billion in emergency funding for federal agencies to respond to the coronavirus outbreak.
- Highlights
  - Granted the Secretary of HHS broad discretion, under Section 1135 of the Social Security Act, to waive Medicare statutory rural and site of service coverage restrictions on services provided via telehealth.

# Section 1135(b)(8) Waiver

- Retroactive to March 6, 2020
- Waives Medicare coverage for telehealth services regardless of whether patient is in a rural area
- Waives the “originating site” requirement, meaning services can be provided to beneficiaries in any healthcare facility, as well as in their home.
- Is not limited to telehealth services related to COVID-19 and applies to any medically necessary covered service.

# Medicare Advantage and Telehealth Waiver

- Medicare Advantage Plans are required to cover the same services as regular Medicare Parts A and B (42 CFR Section 422.201)
- Because Medicare Part B is now covering telehealth in non-rural areas and when patient is in the home, this should mean that Medicare Advantage plans must provide the same coverage.
- Previously, MA plans had the option of providing expanded telehealth benefits as part of their basic benefits.

# Distant Site

- Where the physician or practitioner is located at the time the service is provided, via a telecommunications system.
- FQHCs and RHCs added as distant site providers
- Eligible distant site providers
  - Physicians
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Nurse-midwives
  - Clinical nurse specialists (CNSs)
  - Certified registered nurse anesthetists
  - Clinical psychologists (CPs)
  - Clinical social workers (CSWs)
  - Registered dietitians or nutrition professionals
  - FQHCs and RHCs
- Does not include physical or occupational therapist.

# New Telehealth Services

- CMS announced, in the IFR, broad expansion of services that can be provided via telehealth.
- Covered services now include, among others:
  - Emergency department visits
  - Observation day management
  - Critical care
  - Home visits
  - Intensive care
  - Radiation treatment management

# New and Established Patients

- Established Patient Requirement Eliminated for:
  - Medicare telehealth services (e.g., E/M visits conducted via audio-visual real time communication) can now be provided to new and established patients.
  - Remote patient monitoring
  - Telephone calls and virtual check-ins
  - Digital e-visits



# Telehealth Billing Requirements

- “Originating site” facility fee claims must include HCPCS code “Q3014.”
  - Current originating site fee for CY 2020: \$26.65
- “Distant Site” (i.e. where clinician is located) bills same CPT/HCPCS code they would bill if service provided in person (e.g., E/M codes)
- Use modifier 95 and Place of Service (POS) code that would be used if service provided in person. (Note, under IFR, practitioners should not use POS 2)
- Medicare pays the same amount for telehealth services as it would if the service were furnished in person.
  - Use the designated CPT code that describes the service.
  - Medicare will now pay at higher non-facility rate for services provided in physician office (POS11)

# FQHCs & RHCs

- Medicare restrictions were lifted in the CARES Act
  - Broadens the definition of “distant site” to include FQHCs and RHCs that provide telehealth services to an eligible individual.
  - Telehealth services will be paid based on national average of the physician fee schedule rate.
- The Interim Final Rule (IFR) allows payment to FQHCs/RHCs for online digital visits (CPT Codes 99421-99423) to services covered and billed under HCPCS Code G0071.
- All virtual communication services billed under G0071 are available to new patients as well as established.

# Revised “Incident To” Supervision Rules

- Medicare requires that clinical staff work on “direct supervision” of the practitioner for most services. However, under new rules, “direct supervision” can be performed through audio/video real-time communications technology
- Must be for purpose of reducing exposure risks for the beneficiary or health care provider.
  - Individual practitioners are in the best position to make decisions based on their clinical judgement if their physical presence is necessary.

# Revised “Incident To” Supervision Rules

- Include instances where the physician enters into a contractual arrangement for auxiliary personnel to leverage additional staff and technology necessary to provide care
  - Payment for these services would be made to the billing practitioner who would then make the appropriate payment to the contracted entity.
- Adopted similar changes for diagnostic services furnished directly or under arrangement in the hospital or in an on-campus or off-campus outpatient department of the hospital, as well as pulmonary rehabilitation, cardiac rehabilitation, and intensive cardiac rehabilitation services

# Telephone Calls

- Medicare will now pay for audio-only phone calls
  - Virtual Check-ins; brief 5-10 minute call (HCPCS Code G2012)
  - CPT Codes for telephone calls: 98966-98968 for clinical staff or other professionals (e.g., LCSWs, PTs, OTs, clinical psychologists)
  - Not limited by patient location
  - CPT Codes 99441-99443 for clinicians
  - Cannot be within 7 days of E/M for same problem
  - Cannot lead to E/M or procedure within 24 hours (or first available appt.)

# Digital E-Visits

- Patient-initiated communication between patient and practitioner using online patient portals.
  - No geographic or location restrictions
  - Can only be billed once per 7 days
  - Can range from 5 to 21 or more minutes
- New or established patients
- CPT Codes 99421-99423 (clinicians)
- HCPCS codes G2061-G2063 for Medicare or CPT Codes 98970-98972 (clinical staff; other professionals)
  - CMS Examples: physical therapists, occupational therapists, speech language pathologists, and clinical psychologists can bill G2061-G2063 to Medicare

# Remote Patient Monitoring (RPM)

- Used as follows:
  - Must be for remote monitoring of physiologic parameters
  - Patient can be in their home
  - Monitoring can last several weeks or months
  - Must be for treatment management
  - Can now be for new and established patients
  - Acute or chronic conditions
- Use Codes 99453-99458
- Patient consent required but can be obtained annually – document in medical record

# Frequency Limits for Inpatient/NF Visits

- Removed the frequency restrictions for subsequent inpatient visits and subsequent NF visits furnished via Medicare telehealth for the duration of the PHE for the COVID-19 pandemic.
  - Previously allowed once every 3 days
- Removed the frequency restrictions for certain critical care consultation codes.
  - Previously allowed once per day



# “Hands-on” Visits for ESRD Monthly Capitation Payments

- CMS is permitting the required clinical examination of the vascular access site to be furnished via telehealth.
- Relaxed the requirement that home dialysis patients receive at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months face-to-face visits.

# Medicaid and Telehealth Expansion

- States already have considerable flexibility to cover telehealth under their state plans
- No federal approval is needed to reimburse telehealth visits in same manner as face-to-face services
- Other changes may require waivers but CMS will streamline approval process.
- Over 35 states have been granted section 1135 waivers to date
- CMS COVID-19 Medicaid Waiver [Checklists](#)

# State Activities

- States are taking steps to expand telehealth services to Medicaid beneficiaries with and without federal waivers.
- Center for Connected Health Policy is tracking this around the country. Check for action by your [state](#).

# Examples of What States are Doing

- Coverage for telephone calls
- Coverage for smart phone live chat apps
- Expanding Medicaid coverage of telehealth visits in FQHCs, RHCs, and Indian Health Service
- Allowing home to serve as originating site for telehealth services
- Expanding coverage of services that can be furnished via telehealth without prior in-person visit
- Waiving cost-sharing requirements

# Examples of What States are Doing (cont'd)

- Allowing out-of-state practitioners to provide services to residents via telehealth
- Allowing prescriptions for Schedule II-IV controlled substances via telehealth
- Adding new services like physical and occupational therapy to covered telehealth services
- Expanding behavioral health services and substance abuse counselling
- Allowing telehealth visits for new patients

# RESOURCES

- [\*\*MEDICARE TELEHEALTH FAQs\*\*](#)
- [\*\*MEDICARE TELEMEDICINE TOOLKIT\*\*](#)
- [\*\*MEDICARE TELEMEDICINE FACT SHEET\*\*](#)
- [\*\*MEDICARE INTERIM FINAL RULE\*\*](#)

# STATE LICENSURE

## PEGGY TIGHE

# Telehealth, Focus on State Licensure

- 1135 Waivers

Section 1135 of the Social Security Act dissected and explained...

- the Secretary may temporarily waive or modify...
- certain **Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements...**
- to ensure that sufficient health care items and services are available...
- to meet the needs of individuals enrolled in Social Security Act programs...
- in the emergency area and time periods and that providers who provide such services in good faith...
- can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).



# Telehealth, Focus on State Licensure (cont'd)

- 1135 Waivers Examples
- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals hold licenses in the State in which they provide services if they have a license from another State and are not affirmatively barred from practice in that State or any State in the emergency area (note however, that this waiver is for the purposes of Medicare, Medicaid, and SCHIP reimbursement only – states determine 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 health care items and services furnished to Medicare Advantage enrollees by non-network providers

Source (CMS): <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/1135-Waivers>

# Telehealth, Focus on State Licensure (cont'd)

- 1135 Waiver, Licensure Dissected
- Requirements that physicians and other health care professionals hold licenses in the State in which they provide services ...
- if they have a license from another State ...
- and are not affirmatively barred from practice in that State or any State in the emergency area ...
- note however, that this waiver is for the purposes of Medicare, Medicaid, and SCHIP reimbursement only...
- **states determine whether a non-Federal provider is authorized to provide services in the state without state licensure.**

# Telehealth, State Licensure

## EXAMPLE

- A physician in good standing is licensed in the District of Columbia, lives in Maryland, and is not licensed to practice medicine in Maryland or Virginia.
- Given the President's announcement on telehealth regarding the "blanket waivers", the physician seeks to care for a patient just five miles away in Arlington, Virginia using two-way, audio and visual communication.
- The patient is insured through the Children's Health Insurance Plan (CHIP).
- The state of Virginia has received an 1135 waiver of physician licensure restrictions.

*Can the physician seek reimbursement for telehealth services provided to the patient?*

# Telehealth, State Licensure

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*Can the physician seek reimbursement for telehealth services provided to the patient?*

## ANSWER

YES. The new "blanket waivers" cover this situation but only for Federal payors (in this case, CHIP).

# Telehealth, State Licensure (cont'd)

## IMPORTANT CAVEATS

### WHICH PROVIDERS

- Not all health care professionals are covered by this set of waivers.
- Consult with your national or state health professional association.
- FQHCs were not covered in the first telehealth package, later corrected, status of FQHC look-alikes remains in question.

### ACTION NEEDED

- Health care providers should submit requests to the CMS Regional Office with a copy to the State Survey Agency (\*see resources slide at end).
- Keep detailed records, reimbursement is the same, must be for otherwise reimbursable services.

### MODE of COMMUNICATION

- Communications must be two way and audio-visual. Efforts to make certain exceptions underway.

# Telehealth, State Licensure (cont'd)

## IMPORTANT CAVEATS

### CHECK STATE LAWS/RULES

Some states have more flexible telehealth and licensure provisions, **check state law/rules.**

- Reimbursement by commercial payors (non-Federal payors) is governed by STATE LAW.
- Licensure is also regulated by states (10<sup>th</sup> amendment to U.S. Constitution) and is most often tied to where the patient is located.
- Secretary Azar sent a letter to Governors on March 24 asking for more across-state-lines licensure relief. Most states are engaged, but continually changing.
- National Governor's Association calling for states to provide more flexibility: [NGA Released Recommendations to States](#)
  1. Expanding access to out-of-state licensed health care providers and telehealth.
  2. Maintaining and increasing the number of providers by easing in-state licensure requirements.
  3. Expanding medical facility and testing capacity by temporarily loosening licensure and reimbursement requirements for facilities

# Telehealth, State Licensure (cont'd)

## IMPORTANT RESOURCES

- [1135 Waivers At A Glance \(PDF\)](#)
- [Requesting an 1135 Waiver 101 \(PDF\) \\*](#)
- [CMS Presentation on 1135 Waivers \(PDF\)](#)
- [1135 Waivers Authority \(PDF\)](#)
- [Information to Provide for an 1135 Waiver Request \(PDF\)](#)
- [PHE Questions and Answers \(PDF\)](#)

# FEDERAL WAIVERS RELATED TO TELEHEALTH

## BARBARA STRAUB WILLIAMS



# Telehealth and HIPAA Waiver

- Relaxation of HIPAA Requirements for Telehealth
  - HHS will not impose HIPAA penalties if “good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency.” Telehealth service does not have to be related to COVID-19.
  - See Waiver Notice for acceptable and unacceptable applications, as well as vendors that are HIPAA compliant and will sign a BAA
  - Waiver Notice: <https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>
  - Special rules apply to records of patients with substance use disorder: Special Rules: <https://www.samhsa.gov/sites/default/files/covid-19-42-cfr-part-2-guidance-03192020.pdf>

# Telehealth and Sanctions for Waiver of Beneficiary Payments

- HHS-OIG *will not* impose sanctions on practitioners for waiving copayments on telehealth services or providing free telehealth services. Telehealth service does not have to be related to COVID-19.
- Conditions:
  1. The cost-sharing obligation must be related to telehealth services furnished consistent with the then-applicable coverage and payments rules; and
  2. The telehealth services are furnished during the time period subject to the COVID-19 public health emergency declaration.
- **OIG Policy Statement on Telehealth:**  
<https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf>

# Telehealth and DEA Waiver for Controlled Substances

- Controlled substances may be prescribed as the result of a telehealth visit for a new patient if:
  - The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
  - The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
  - The practitioner is acting in accordance with applicable Federal and State law

# DEA Waiver on Telehealth Prescriptions for Controlled Substances (cont'd)

- See waiver for information on whether Rx may be submitted via e-prescribing or telephoned to pharmacy
- Controlled substances may be prescribed for established patients through telephone
- DEA Waiver:  
<https://www.dea diversion.usdoj.gov/coronavirus.html#TELE>

# Stark Waiver

- CMS waiver of certain Stark prohibitions
  - Must relate to a direct financial relationship between a physician and provider
  - Must be in response to COVID-19
    - CMS example of permissible action under waiver:
      - An entity provides free telehealth equipment to a physician practice to facilitate telehealth visits for patient
- CMS Waiver:  
<https://www.powerslaw.com/wp-content/uploads/2020/03/Stark-Waivers.pdf>

# 340B PATIENT DEFINITION

## BARBARA STRAUB WILLIAMS

# 340B Patient Definition – Telehealth

- Internal Apexus FAQ:
  - Question: Is telemedicine an eligible service to qualify for 340B drug pricing in a covered entity?
  - Answer: In the case of eligible hospitals, the clinic at which the covered entity provides healthcare services must be an integral part of the hospital, listed as reimbursable on its Medicare cost report. In the case of all other covered entities, the patients must be provided healthcare services by the covered entities that are within the scope of the grant or other statutory basis for eligibility. The entity is responsible for meeting the definition of a patient. For more information on the definition of a patient please see [HRSA 1996 patient definition guidance].

# Telehealth and 340B

- Given the coronavirus 2019 pandemic, what flexibilities are available to entities to allow a provider to offer telehealth services?
  - HRSA understands that the use of technology in health care delivery during this time is critical, and that telemedicine is merely a mode by which the health care service is delivered. . . HRSA recommends that covered entities outline the use of these modalities in their policies and procedures and continue to ensure auditable records are maintained for each eligible patient dispensed a 340B drug.
- HRSA OPA COVID-19 Resources Webpage FAQs:  
<https://www.hrsa.gov/opa/COVID-19-resources>



# Telehealth and 340B – Apexus Guidance on Location of Prescriber and Patient

- In the past, HRSA has focused on whether the site where services are provided is a 340B-eligible site to determine whether an Rx written as the result of the service may be filled with 340B drugs. Question: if the prescriber and patient are each at home, may an Rx written as the result of a telehealth visit be filled with 340B drugs?
- Powers conversation with Apexus – If the prescriber is logged into the CE's EMR, such that the EMR reflects that the telehealth visit is taking place through a 340B eligible site, an Rx written as the result of that visit may be filled with 340B drugs.

# Telehealth and 340B – Scope of Grant

- For 340B grantees, acting within the scope of the grant is important to:
  - 1) Comply with grant requirements; and
  - 2) Comply with third prong of 340B patient definition

# Telehealth and 340B – Scope of Grant – RW Clinics

- HRSA HAB (oversees Ryan White clinics) confirmed that providing telehealth services, even when provider works from home, or uses a telephone only, is within the scope of the Ryan White grant:
  - Can providers do telehealth from their home or do they need to be at the RWHAP clinic?
  - Can a telephone call count as a telehealth visit?
- “HRSA HAB encourages the use of telehealth to promote access to and continuity of care in a safe way during social distancing.”
- HRSA/HAB Coronavirus FAQs: <https://hab.hrsa.gov/coronavirus-frequently-asked-questions> for entire text

# Telehealth and 340B – Scope of Grant – FQHCs/LAs

- HRSA Bureau of Primary Care (FQHCs and FQHCs – LAs)
  - Can a health center use telehealth to provide services to a patient at a location that is not an in-scope service site? Can this occur if neither the health center provider nor the patient is at an in-scope service site (e.g., both the provider and patient are at their respective homes)?
    - Yes, FQHC not required to request change in scope.
  - May health centers provide in-scope services through telehealth to individuals who are not current health center patients?
    - Yes, for duration of PHE
    - Provider must be at FQHC or other location (inc. home) on behalf of FQHC
- BPC Coronavirus FAQs:  
<https://bphc.hrsa.gov/emergency-response/coronavirus-frequently-asked-questions.html>

# Relaxed Documentation Standards for Patient Definition

- OPA will accept an abbreviated medical record, self-reporting of patient medical and insurance information, and contact information for volunteer health workers to support patient relationship
- These relaxed documentation standards apply to all health care visits, not just telehealth

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