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Medicare Telehealth Policies During the COVID-19 Pandemic

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Updated on June 1, 2020

Over the last several weeks, Powers has been reporting on the telehealth expansion during the COVID-19 pandemic. (More information is available on the Powers website.) The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), enacted on March 27, 2020 and the Centers for Medicare and Medicaid Services (CMS) Interim Final Rule (IFR), issued on March 31, both contain significant telehealth provisions. CMS has also been issuing a steady stream of guidance regarding implementation of these provisions, although many questions still remain unanswered. On April 30, 2020 CMS issued a new series of updates including new waivers and a new IFR. This series of Q & As address many of the temporary telehealth provisions that apply during the COVID-19 public health emergency (PHE) including the April 30, 2020 announcements. Powers will be updating this document as the Administration continues to issue additional guidance. The information contained in this document shall not be considered legal advice but should be instructive for providers seeking to be in compliance with laws, regulations, and guidance that are being issued and changed frequently.

Medicare Billing and Claims Requirements

1. ***What place of service (POS) and modifiers should be used on the Medicare claim to signify that a provider is furnishing health care services via telehealth instead of in person?***

Physicians and qualified health practitioners (QHPs) furnishing outpatient telehealth services during the PHE should use the POS code that they would have otherwise used had the service been provided in person. Medicare is no longer requiring use of the POS 2 code. CMS requires providers to also include the 95 modifier to identify services as a Medicare telehealth service.

Additionally, providers should continue to use any special modifiers that applied prior to the COVID-19 PHE (i.e. “GQ”, “GT”, or “G0”).

2. ***Will clinicians be paid the same amount by Medicare for telehealth services as they would for in-person services?***

Yes. During the COVID-19 PHE, Medicare will reimburse the same rate as the physician/QHP would receive had the patient been seen in person. Office-based physicians/QHPs (POS 11) will be reimbursed the higher non-facility rate. This rate will apply even if the physician provides the telehealth service from his/her home. If the physician normally sees patients in a hospital outpatient department or provider-based clinic, then they would be paid the facility rate for telehealth services, just as they normally would.

3. ***What if the physician provides telehealth services from his/her home?***

In order to prevent the spread of COVID-19, many physicians/QHPs are choosing to provide telehealth services from their home. CMS has stated that there will be no payment restrictions on distant site practitioners who provide telehealth services from their home during the PHE. Medicare will pay the same amount for telehealth services as if the services were provided in person. Providers should use the CPT code that properly describes the service and include both the 95 modifier and the POS code that would have been used had the service been provided in person.

4. ***Can hospitals in non-rural areas bill an originating site fee?*** **(Updated 5/4/2020)**

Yes. Where a practitioner that normally practices in the hospital outpatient department (HOPD) furnishes services via telehealth to a registered hospital outpatient, the hospital can bill Medicare an originating site fee to cover its administrative and clinical support services. CMS announced this policy, in the April 30, 2020 IFR and applies to services provided on or after March 1, 2020.

5. ***Can we get paid for a telehealth visit if the patient and the physician/QHP are in the same location (e.g., in the hospital or provider-based clinic) but the service is furnished via telecommunications technology due to exposure risks?***

In this case, because the physician and patient are in the same location, CMS has instructed that the visit be treated as an in-person rather than a telehealth visit. Thus, while the physician/QHP would get reimbursed for the service, the service does not need to be identified as a telehealth service.

6. ***How should the evaluation and management (E/M) code level be selected when the service is provided via telehealth?*** **(Updated 5/4/2020)**

During the PHE, CMS will allow outpatient visit codes to be based on medical decision making or time, even if counseling and coordination of care are not 50% of the visit. CMS announced, in the April 30, 2020 IFR, that practitioners should use the times set forth in the CPT Code descriptors in selecting the E/M level when coding based on time.

7. ***Do I need to change my enrollment status now that I am providing health care services to Medicare beneficiaries from home?***

No. Medicare physicians/QHPs do not need to update their enrollment status to notify CMS that they are providing telehealth services to Medicare beneficiaries from their homes.

8. ***Are there limits on how often Medicare telehealth services can be provided in certain institutional settings?***

Yes; however, CMS has relaxed many of these limits during the PHE. Before the COVID-19 PHE, CMS imposed restrictions on how frequently a Medicare service may be furnished via

telehealth in certain settings. Specifically, hospitals could only provide and bill for telehealth subsequent inpatient services once every three days, critical care consultation could only be billed once per day, and skilled nursing facilities (SNF) could only bill once every 30 days. During the PHE, CMS lifted these frequency limitations for subsequent inpatient, critical care, and SNF visits furnished via telehealth.

CMS is also permitting the required clinical examination of the vascular access site for patients receiving home dialysis to be furnished via telehealth. The pre-COVID-19 requirement was that home dialysis patients must receive face-to-face visits 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.

Outpatient Therapy Services

9. ***Can physical therapists, occupational therapists, and speech language pathologists bill as distant site providers?*** **(Updated 5/4/2020)**

Yes. On April 30, 2020, CMS announced that pursuant to waiver authority under the CARES Act, it was expanding the types of practitioners that may bill for telehealth services as "distant site" providers. Retroactive to March 1, 2020, physical therapists, occupation therapists, speech language pathologists and other professionals that bill Medicare directly can receive reimbursement for services provided via telehealth, provided those services are on the list of eligible telehealth services.

10. ***Can institutional providers furnish and bill for therapy services (e.g., physical or occupational therapy) via telehealth?*** **(New 5-27-2020)**

Yes. A hospital outpatient department can bill for these services on the institutional claim form (e.g.UB-04) and should append modifier 95. SNFs cannot be paid separately for therapy services if the patient's stay is covered by Medicare Part A because therapy services are bundled into the SNF prospective payment system. SNFs may be able to bill Medicare Part B for therapy services provided via telehealth if the patient is in a non-covered stay.

FQHCs and RHCs

11. ***Can FQHCs and RHCs get reimbursed for telehealth services?*** **(New 5-27-2020)**

Yes. Congress, in the CARES Act, extended the definition of "distant site provider" to include federally qualified health centers (FQHCs) and rural health clinics (RHCs). In its May 27, 2020 FAQs, CMS clarified that FQHC look-alikes are also eligible to bill for services furnished on or after January 27, 2020.

12. ***How should FQHCs and RHCs bill for telehealth services?***

For distant site services provided between January 27, 2020 and June 30, 2020, RHCs and FQHCs must put modifier 95 on the claim. These claims will be paid based on the FQHC PPS rate or the RHC AIR rate but will be automatically reprocessed in July when the Medicare claims

processing system is updated. The new payment rate will be $92, an amount based on the national average of the physician fee schedule rate for comparable telehealth outpatient visits. For services furnished between July 1, 2020 and the end of the COVID-19 PHE, RHCs and FQHCs should use the new G code, G2025 to identify telehealth distant site services. Claims with the new G code will also be paid at the $92 rate. For more information see https://www.cms.gov/files/document/se20016.pdf

13. ***Can RHCs and FQHCs bill for communication technology-based services?*** **(New 5-27-2020)**

Yes. When billing for on-line digital E/M services (CPT Codes 99421-99423) or for virtual check-ins or remote evaluations (G2012 and G2010) they should use HCPCS Code G0071. The payment rate for 2020 is $24.76.

Communication Technology Based Services

14. ***Can a physician or QHP provide direct supervision through remote audio/visual technology rather than being on-site?***

Yes. During the COVID-19 PHE, physicians/QHPs can satisfy the "direct supervision" requirements outlined in the Medicare "incident to" rules using real-time interactive audio and video technology where the physician or QHP deems it necessary for the purpose of reducing exposure risks for the beneficiary and health care provider

These same rules apply to 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.

15. ***Many Medicare patients do not have access to or do not know how to use audio/visual communication systems such as smart phones or still rely on landlines. Will Medicare pay for audio-only calls during the COVID-19 PHE?*** **(Updated 5/4/2020)**

Yes. Medicare will cover audio-only calls under new coverage for telephone E/M services billed under CPT Codes 99441-99443 when provided by physicians/QHPs. Medicare also covers virtual check-ins (HCPCS Code G2012), which are described as brief phone calls of 5-10 minutes. Payment for audio-only calls is less than it is for E/M services that are provided via telehealth with real time audio-visual communication systems.

16. ***Will Medicare pay for audio-only E/M services at the same rate as if provided via audio and visual communications*****?** **(Updated 5/4/2020)**

Medicare will pay for audio-only telephone E/M services provided by physicians/QHPs at the same rate it pays for established patient E/M visits provided via telehealth. Specifically, CMS is crosswalking CPT codes 99212, 99213, and 99214 to 99441,99442, and 99443, respectively. This policy is retroactive to March 1, 2020.

17. ***Will Medicare pay for phone calls if done by clinical staff rather than a physician or QHP?***

Yes. Medicare will cover phone calls by clinical staff as well as other nonphysician health care professionals under CPT Codes 98966-98968. The purpose of the call must be assessment and management of the patient and not, for example, related to scheduling or billing.

18. ***What is the government doing to improve broadband access to all areas of the country during the PHE?***

Congress, as part of the recent CARES Act, appropriated $200 million to help health care providers expand their ability to provide telehealth services by funding their telecommunication services, information services, and devices to provide connected care. The FCC has also issued temporary authorization to 33 wireless internet service providers to increase their broadband capacity. HHS, through the Health Resources and Services Administration (HRSA) awarding CARES Act grants to health centers that may be used to boost telehealth capacity.

19. ***What other practitioners can bill for phone calls?*** **(Updated 5/4/2020)**

Medicare will reimburse phone calls by licensed clinical social workers, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists and other non-physician professionals with independent billing rights using CPT Codes 98966-98968 provided the call pertains to a service that falls within the benefit category of those practitioners. Note, however, that these practitioners can also bill for services on the telehealth list including audio-only.

20. ***Are these telephone services covered when provided to new patients?***

Yes. They are covered for both new and established patients during the COVID-19 PHE.

21. ***Can psychotherapy be provided via audio-only telephone?*** **(Updated 5/4/2020)**

Yes, effective March 1, 2020, psychotherapy services can be provided via audio-only communications. Practitioners should consult the CMS list for psychotherapy and related services that can be furnished via audio-only communications.

22. ***Can a physician or QHP use telecommunications to provide services under the Opioid Treatment Program (OTPs)?*** **(Updated 5/4/2020)**

Yes. In the first IFR issued on March 31, CMS announced that physicians or QHPs could provide the therapy and counseling portions of the weekly bundled OTP service using audio-only communications rather than a two-way telecommunication system. CMS included additional flexibilities for OTP physicians and QHPs in the April 30 IFR by allowing periodic assessments to be furnished through two-way telecommunication systems, or through telephone calls if a two-way telecommunication system is not available. OTP physicians and QHPs should use clinical

judgment in determining whether a periodic assessment can be adequately performed over a telephone call.

23. ***Can services such as digital e-visits be provided to new patients?***

Yes. CMS has clarified that all telehealth and communication technology-based services (CTBS) services can be provided to new patients as well as established patients during the PHE.

24. ***Do digital e-visits and phone calls have to be initiated by the patient?***

Yes. Medicare requires that these services be patient-initiated. However, CMS has stated that it will be flexible in its interpretation and that patients can give general consent to the provider contacting them at the same time the service is furnished.

Remote Patient Monitoring

25. ***How should patient consent be obtained when providing remote patient monitoring (RPM) services?***

Medicare requires that patients be informed of cost-sharing obligations and has clarified that consent can be obtained at the time of service and through the use of auxiliary personnel.

26. ***Has CMS waived the 16-day requirement for remote patient monitoring (RPM) services?*** **(Updated 5/4/2020)**

Yes, with certain conditions. During the PHE, providers can report the RPM Codes (CPT codes 99453, 99454, 99457, 99458 and 99091 for monitoring services that last less than 16 days but at least two days, and only for monitoring of patients with a suspected or confirmed diagnosis of COVID-19.

27. ***Can remote patient monitoring be used for acute conditions such as post-surgical wound healing?***

Yes. CMS has clarified that RPM is covered for both acute and chronic conditions.

28. ***Can independent diagnostic testing facilities (IDTFs) provide remote patient monitoring services?***

According to CMS staff, IDTFs can provide the technical components of remote patient monitoring (CPT Codes 99453 and 99454) under contract to a provider such as a physician practice but cannot bill Medicare directly for RPM.

Waiver of Co-payments

29. ***The HHS Office of Inspector General has stated that it will not enforce rules related to waiver of patient co-payments for telehealth services during the PHE. Does this mean physicians/QHPs are required to waive co-payments?***

No. There is no requirement that a provider waive Medicare co-payments for telehealth services.

30. ***Does the non-enforcement related to waiver of copayments apply only to telehealth visits or does it also apply to CTBS?***

The non-enforcement related to co-payment waivers applies to both telehealth services and CTBS services such as telephone calls and digital e-visits. Further, they do not have to be related to COVID-19 care.

State Licensure

31. ***Must practitioners be licensed in the state where the patient is in order to provide telehealth services?***

It depends on the state. Although the federal government has provided a blanket waiver to licensed practitioners to furnish telehealth services outside their state of licensure, practitioners must still comply with licensure requirements of the state where the patient is located as well as those of their own state. Many states have waived or relaxed licensure requirements for telehealth during the PHE. You will need to check requirements of your state as well as the state where the patient is located. The Federation of State Medical Boards maintains of list of state licensure policies. https://www.fsmb.org/advocacy/covid-19/ For other types of practitioners check with your state or national licensing organization.

Prescribing Via Telehealth

32. ***Can drugs prescribed as a result of a telehealth visit qualify as 340B?***

Yes. A prescription that is written as the result of a telehealth visit may be filled with 340B drugs, provided that the three prongs of HRSA' s patient definition are met:

- the prescriber must be employed by or under contract with the covered entity, or have received a referral from the covered entity;
- the covered entity must have medical records of the telehealth visit; and
- the service provided via telehealth must be within the scope of the covered entity' s grant.

The third requirement above is applicable only to grantees and not hospitals. HRSA also confirmed on the HRSA/OPA COVID-19 Resources page that telehealth is an acceptable modality for providing care. Apexus, the HRSA prime vendor, has stated informally that a prescription resulting from a telehealth visit may be filled with 340B drugs even if the prescriber

and patient are at home. The telehealth visit should be recorded in the hospital's EMR in the same way that in-person visits at 340B eligible locations are recorded. The HRSA/OPA COVID-19 Resources page also states that covered entities should include provisions about the use of telehealth to qualify prescriptions for 340B in their policies and procedures and keep auditable records.

33. *Can a practitioner prescribe controlled substances via telehealth*?

Yes. A DEA-registered practitioner may issue prescriptions for controlled substances to patients with whom they have not conducted an in-person visit. 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.

The provider must also ensure that state law allows for controlled substances to be prescribed via telehealth.

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For further questions regarding telehealth policies or any other COVID-19 related issues, please contact Rebecca Burke or Megan La Suer or any Powers professional with whom you normally work. Contact information for all professionals and practice groups can be found at https://www.powerslaw.com/professionals/.

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