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Healthsperien COVID-19 Special Flexibility Summary
Telehealth Flexibilities

In this resource we provide an overview of COVID-19 telehealth flexibilities, which apply retroactively beginning March 1, 2020. Please contact Priya Lamba at plamba@healthsperien.com or visit the Healthsperien COVID-19 Resource Updates page for additional resources, and if you are facing COVID-related policy issues.

Medicare Telehealth Coverage

CMS has issued several guidance documents on expanded Medicare telehealth coverage—Medicare Telemedicine Provider Fact Sheet, Medicare Telehealth FAQs, and CMS Blanket Waivers Summary. CMS also released the COVID-19 Interim Final Rule (IFR), in which it provides additional telehealth flexibilities. The flexibilities detailed in the guidance above are summarized below. Additional details are provided in Appendix A.

Issue/Topic	Guidance
Evaluation and Management (E/M)	CMS has temporarily expanded telehealth coverage (using real-time audio and visual technology) for additional in-person codes, including the following: Office/Outpatient E/M Codes; Home/Domiciliary E/M Services. CMS is permitting provision of services for both new and established patients. A full list of the covered codes can be found here.
Place of Service (POS)	Bill using the POS you would normally use for an in-person service. This will warrant the same reimbursement rate as if the service was furnished in person. You may continue billing using POS-2 for Telehealth (per CMS's previous guidance), however, services with POS-2 will be reimbursed under the facility payment rate, which is an unadjusted flat rate.
Modifiers	**If you bill with your normal in-person POS (not POS-2),** you will need to include Modifier -95 to indicate that the service was furnished via telehealth. Additional or different modifiers are required under the following three instances: • GQ – telehealth services furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii • GT – telehealth services furnished under CAH Method II • G0 – telehealth services furnished for the purposes of diagnosis and treatment of an acute stroke Additionally, private practice occupational and physical therapists, and speech-language pathologists, will need to include their respective GO, GP, or GN therapy modifier for "sometimes therapy" services.
Other Common Codes	Transitional Care Management, Advance Care Planning, Annual Wellness Visits, Telephone Assessment and Management, Administration of Caregiver-Focused Health Risk Assessment Instrument
Direct Supervision Requirements	CMS is permitting direct supervision requirements to be met virtually, using real-time audio and visual technology.

By billing for telehealth services as if furnished in person, providers do not need to worry about originating and/or distant sites. In the IFR, recognizing that practice costs for furnishing telehealth services during the public health emergency (PHE) may not significantly differ, CMS believes that the payment should reflect the rate that would have been paid as if the services were furnished in person.

Additionally, CMS has clarified that initial nursing assessments can be conducted via telehealth. Specifically, for hospices, in recent office hours session, CMS has clarified "that hospices may use telehealth to the extent the use of telehealth is actually capable of providing a full assessment of a patient and caregivers need. And that is

really what it comes down to as far as compliance is concerned: Were you able to fully assess the patient's needs in a way that allows you to develop accurate care plan and deliver services."

Hospitals, Nursing Homes, Home Health Agencies (HHAs), and Other Facilities

In the COVID-19 IFR, CMS has extended telehealth flexibilities and coverage to additional settings of care including, among others, for hospitals, HHAs, long-term care facilities (skilled nursing facilities and nursing facilities), inpatient rehabilitation facilities, End-Stage Renal Disease (ESRD) facilities, hospices, and rural health centers (RHCs) and federally-qualified health centers (FQHCs).

CMS Telehealth Toolkits

CMS released telehealth toolkits for general practitioners, end-stage renal disease providers, and long-term care nursing homes. Each toolkit contains a list of information from CMS and other entities on telehealth and telemedicine, including general information on telehealth, telemedicine vendors, how to initiate a telemedicine program, monitor patients remotely, and develop documentation tools. Additionally, the information contained within each toolkit outlines how to use temporary virtual services (e.g. Skype and FaceTime) to treat patients during the duration of the COVID-19 Public Health Emergency.

Medicaid Telehealth Coverage

CMS has issued two guidance documents on Medicaid telehealth coverage: Medicaid State Plan FFS Payments for Services Delivered via Telehealth and CMS Medicaid FAQs. However, Medicaid telehealth flexibilities and coverage vary state to state. For additional information on what's happening in your state, please see the following resources: Medicaid Telehealth page; Collection of State Medicaid Telehealth Changes; and the National Governors Association's (NGA's) page.

Medicare Advantage (MA) and Part D

CMS is permitting MA and Part D plans to waive cost-sharing for telehealth services and to expand their telehealth services. Even prior to the COVID epidemic, MA and Part D plans were permitted broadly expand their telehealth offerings in their basic and supplementary benefit packages. The new flexibilities in Original Medicare (Parts A & B) will continue to drive that trend.

HHS Office of Civil Rights (OCR) Eases Telehealth Enforcement Guidance

The OCR released three pieces of guidance: two Notifications of Enforcement Discretion, noting it **will not impose penalties for HIPAA violations** against providers **for good faith provision of telehealth,** or against providers or their business associates **for good faith uses and disclosures of PHI for public health and health oversight activities during the PHE; and** guidance on sharing patient information, specifying when patient authorization is not necessary. Key guidance includes:

- Sample platforms you **MAY** use: Apple Facetime, Facebook Messenger video chat, Google Hangouts video, Skype, Skype for Business, Updox, VSee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet
  - "Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications."
- You **CANNOT** use public-facing application, *e.g.*: Facebook Live, Twitch, TikTok

These flexibilities were reinforced in the IFR, in which CMS also clarified that the OIG's enforcement discretion applies broadly to non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-ins, monthly remote care management, monthly remote patient monitoring, etc.

In the COVID-19 IFR, CMS also clarified that "multimedia communications equipment that includes, at a minimum, audio and visual equipment" (e.g., smartphones) can be used to furnish telehealth services.

Telehealth Funding Opportunities

The CARES Act provides **$29 million in grant funding through 2025 to support evidence-based telehealth networks and telehealth technologies**. Visit HRSA website for more information.

Federal Communication Commission (FCC) is using **$200 million of CARES Act funding to establish telehealth grant program** to help eligible providers purchase necessary telecommunications, broadband connectivity, and devices. Applications for receiving funding under the program are now available, and additional guidance is available on FCC's COVID-19 Telehealth Program page. Key details are summarized in the chart below. Additionally, the FCC will make **$100 million available under Connected Care Pilot Program**.

Eligible Providers	Individual or consortia of the following provider entities: • Post-secondary education providers, including teaching hospitals and medical schools • Community health centers, mental health centers, and health centers furnishing care to migrant populations • Local health departments/agencies • Not-for-profit hospitals • Rural health clinics (RHCs) • Skilled nursing facilities (SNFs)
Application Steps	**Step 1:** Obtain eligibility determination from Universal Service Administrative Company (USAC) • Those without USAC Eligibility Determination: complete FCC Form 460 using My Portal – you do not need to be an RHC to submit this form **Step 2:** Obtain an FCC Registration Number (FRN) (you will need your Tax Identification Number – TIN), from the Commission Registration System (CORES), as well as a CORES username and password **Step 3:** Register with System for Award Management **Step 4:** Complete application and email to TelehealthApplicationSupport@fcc.gov
Application Information	• Applicant information (e.g., NPI, EIN, business type, etc.) • Contact information • Health care provider information • Medical services to be provided with funding • Conditions to be treated with the funding • Purpose and intent of funding; including if/how funds will be used for vulnerable populations • Amount requested; if funding is for devices, who will use them and how are they integral to care
Funding	The FCC does not anticipate awarding more than $1 million per awardee per application. Applicants may reapply if they exhaust funds from first award.
Eligible Expenses	• Voice and internet connectivity services for providers or their patients • Remote patient monitoring platforms and services • Patient reported outcome platforms • Store and forward services • Synchronous video consultation platforms • Internet connected devices/equipment, including tablets, smart phones, devices to receive connected care services at home (e.g., broadband enabled blood pressure monitors), telemedicine kiosks/carts
Additional Resources	FCC Application Process Webinar Slides Telehealth Program FAQs Application Process Guidance and Instructions

APPENDIX A

Type of Service	HCPCS/CPT Code	Patient Relationship	Billing	Other Information
Medicare Telehealth Visits	**Office/outpatient codes** 99201-99215 **Home/Domiciliary codes** 99341-99350 **Therapy Service codes** (Multiple code sets) **Transitional Care Management** 99495 and 99496 **Advance Care Planning** 99497 and 99498 **Annual Wellness Visits** G0438 and G0439 **Administration of caregiver-focused health risk assessment instrument** 96161 **Telehealth ED/Inpatient Initial Consult & Follow-Up** G0406-G0408, G0425-G0427 Complete list of telehealth services	For new* or established patients	***Place of Service:*** Normal POS code as if service furnished in person (will receive normal in-person reimbursement); **or** POS-2 Telehealth (will receive flat unadjusted facility rate) ***Modifiers:*** Modifier -95 if billing normal POS. Modifiers are also required for the following three instances: GQ – when services are furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii GT – when services are furnished under CAH Method II G0 – when services are furnished for the purposes of diagnosis and treatment of an acute stroke ***Cost-Sharing***: Providers have flexibility to waive cost-sharing for visits paid by federal healthcare programs	Services can be furnished in any health care facility and in the home No changes made to scope of practice requirements
Virtual Check-Ins	**Brief (5-10 mins) communication technology-based service** G2012 **Remote evaluation of recorded video and/or images submitted by an established patient** G2010 **Telephone E/M** 99441-99443 **Telephone assessment and management for established patients/parent/guardian** 98966-98968	For new* and established patients	Medicare coinsurance, deductible, and cost-sharing generally apply Can be billed by licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists ***Cost-Sharing***: Providers can waive cost-sharing for visits paid by federal healthcare programs	For G2010 and G2012, consent can be obtained at time service is furnished by auxiliary staff under general supervision as well as by the billing clinician. In all types of locations (not limited to rural or other locations).
E-Visits	**Online digital E/M, up to 7 days, cumulative time (5 mins – 21+ mins)** 99421 – 99423 **Qualified non-physician healthcare professional online assessment and management, for an established patient, for 7 days, cumulative time (5 – 21+ mins)** G2061 – G2063		Can be billed by clinicians who can't bill for E/M, e.g., PTs, OTs, SLPs, CPs Medicare coinsurance and deductible generally apply ***Cost-Sharing***: Providers can waive cost-sharing for visits paid by federal programs	
Remote Physiological Monitoring	**Collection & Interpretation of Physiological Data, 30 mins** 99091 **RPM Initial Set Up and 30-Day Supply** 99453-99454 **RPM Treatment Management** 99457-99458 **Self-Measured Blood Pressure** 99473-99474	For new* and established patients	Can be used for physiologic monitoring of patients with acute and/or chronic conditions	Annual consent be obtained at time service is furnished. CMS suggests clinician review consent and obtain and document verbal consent

*Temporarily waived or CMS will exercise enforcement discretion