COVID-19 – Expanded Tele-Health Language
for RHCs, FQHCs & Other Safety Net Providers

As it stands right now, the telemedicine "rules" for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) have not changed. An RHC/FQHC may be an origination site and can bill for those services only.

The Expanded Telehealth Benefits to Medicare Beneficiaries During COVID-19 Outbreak guidance does not call out CMS Certified Rural Health Clinics nor Federally Qualified Health Centers as distant sites. In fact, they're not referenced at all.

As a result, these necessary sometimes sole providers will be unnecessarily penalized and the patients they serve placed at risk of imminent harm of contracting and/or spreading COVID-19 if these requirements are not altered.

See the recommendations below that will ensure rural citizens continue to receive the high quality, patient-centric healthcare to which they are accustomed and to ensure the decrease in COVID-19 potency. Implementation of the recommendations below will ensure "…expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of healthcare services from their doctors without having to travel to a healthcare facility…" while allowing these providers the ability to meet the "…urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread."

RECOMMENDATIONS:

In addition to the general guidance provided in the ***CMS MedLearn Matters Special Edition Tuesday, March 17, 2020 -*** *President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak* ***and the Medicare Telemedicine Healthcare Provider Fact Sheet,*** we strongly urge the following recommendation language be enacted immediately and made ***effective March 6, 2020*** (the date of the *National State of Emergency Declaration*):

1. **REMOVE** all language limiting RHC/FQHC telehealth services to originating sites as stated in the ***Medicare Claims Processing Manual Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers*** *80 - Telehealth Services (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)*.

   ADD language that includes **both** originating and distance site status

ADD language deeming any "visit"/"encounter" using telehealth technology consisting of the patient or patient's representative and a Medicare eligible provider (including but not limited to MD, DO, PA, NP, CNM, LCSW, CP, Licensed Family and Marriage Therapist, etc.) a "provider face-to-face" encounter and is therefore paid at the All-Inclusive-Rate/PPS Rate as appropriate. Telehealth technology includes any virtual technology driven platform including but not limited to FaceTime (phone video calls/conferencing capability), Skype, etc.

2. **ESTABLISH and IMPLEMENT** a "flat rate minimum reimbursement" for telehealth services of $175 regardless of payer type for all safety net providers (including but not limited to RHC, FQHC, school-based health center, faith-based clinics, rural private clinics, free and charitable clinics, etc.) during the COVID-19 National State of Emergency Declaration period.

3. **INCREASE** RHC All-Inclusive-Rate to a minimum of $125 per face-to-face provider encounter either in-person on using a virtual technology platform.

4. **ESTABLISH and IMPLEMENT** a supply chain **rural priority designation** to ensure needed supplies reach rural providers. Increased numbers of telehealth visits will result in increased volume of home visits for follow-up which will increase the need for Personal Protective Equipment (including gloves, gowns, N95 masks, splatter masks, etc.), testing supplies (reagent, swabs, etc.), vaccines and medications (as they become available) and other related supplies.

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BACKGROUND INFORMATION:

Medicare Claims Processing Manual
Chapter 9 - Rural Health Clinics/ Federally Qualified Health Centers
80 - Telehealth Services (Rev. 3434, Issued: 12-31-15, Effective: 03-31-16, Implementation: 03-31-16)

RHCs and FQHCs may bill the Telehealth originating site facility fee on a RHC or FQHC claim under revenue code 0780 and HCPCS code Q3014. Telehealth services are the only services billed on FQHC claims that are subject to the Part B deductible. Additionally, a FQHC payment code and qualifying visit HCPCS code are not required when the only service reported on the claim is for Telehealth services. RHCs and FQHCs are not authorized to serve as distant practitioners for Telehealth services.

For more information on Telehealth services please see Pub 100-04, chapter 12, section 190: http://www.cms.gov/Regulations-andGuidance/Guidance/Manuals/Downloads/clm104c12.pdf

FROM THE CMS MedLearn Matters Special Edition Tuesday, March 17, 2020 - President Trump Expands Telehealth Benefits for Medicare Beneficiaries During COVID-19 Outbreak
CMS Outlines New Flexibilities Available to People with Medicare

"…expanded Medicare telehealth coverage that will enable beneficiaries to receive a wider range of healthcare services from their doctors without having to travel to a healthcare facility. Beginning on March 6, 2020, Medicare—administered by the Centers for Medicare & Medicaid Services (CMS)—will temporarily pay clinicians to provide telehealth services for beneficiaries residing across the entire country."

"…taking swift and bold action to give patients greater access to care through telehealth during the COVID-19 outbreak," said Administrator Seema Verma. "These changes allow seniors to communicate with their doctors without having to travel to a healthcare facility so that they can limit risk of exposure and spread of this virus. Clinicians on the frontlines will now have greater flexibility to safely treat our beneficiaries."

"On March 13, 2020, President Trump announced an emergency declaration under the Stafford Act and the National Emergencies Act. Consistent with President Trump's emergency declaration, CMS is expanding Medicare's telehealth benefits under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. This guidance and other recent actions by CMS provide regulatory flexibility to ensure that all Americans—particularly high-risk individuals—are aware of easy-to-use, accessible benefits that can help keep them healthy while helping to contain the spread of coronavirus disease 2019 (COVID-19).

Prior to this announcement, Medicare was only allowed to pay clinicians for telehealth services such as routine visits in certain circumstances. For example, the beneficiary receiving the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary would generally not be allowed to receive telehealth services in their home.

The Trump Administration previously expanded telehealth benefits. Over the last two years, Medicare expanded the ability for clinicians to have brief check-ins with their patients through phone, video chat and online patient portals, referred to as "virtual check-ins". These services are already available to beneficiaries and their physicians, providing a great deal of flexibility, and an easy way for patients who are concerned about illness to remain in their home avoiding exposure to others.

A range of healthcare providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to Medicare beneficiaries. Beneficiaries will be able to receive telehealth services in any healthcare facility including a physician's office, hospital, nursing home or rural health clinic, as well as from their homes.
Medicare beneficiaries will be able to receive various services through telehealth including common office visits, mental health counseling, and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for

COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves or others at risk. This change broadens telehealth flexibility without regard to the diagnosis of the beneficiary, because at this critical point it is important to ensure beneficiaries are following guidance from the CDC including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a healthcare facility when their needs can be met remotely.

President Trump's announcement comes at a critical time as these flexibilities will help healthcare institutions across the nation offer some medical services to patients remotely, so that healthcare facilities like emergency departments and doctor's offices are available to deal with the most urgent cases and reduce the risk of additional infections. For example, a Medicare beneficiary can visit with a doctor about their diabetes management or refilling a prescription using telehealth without having to travel to the doctor's office. As a result, the doctor's office is available to treat more people who need to be seen in-person and it mitigates the spread of the virus.

As part of this announcement, patients will now be able to access their doctors using a wider range of communication tools including telephones that have audio and video capabilities, making it easier for beneficiaries and doctors to connect.

Clinicians can bill immediately for dates of service starting March 6, 2020. Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services. Medicare coinsurance and deductible still apply for these services. 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.
Medicaid already provides a great deal of flexibility to states that wish to use telehealth services in their programs. States can cover telehealth using various methods of communication such as telephonic, video technology commonly available on smart phones and other devices. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services.

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Medicare Telemedicine Health Care Provider Fact Sheet

Medicare coverage and payment of virtual services

INTRODUCTION:

Under President Trump's leadership, the Centers for Medicare & 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 healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. 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 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.

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. Innovative uses of this kind of technology in the provision of healthcare is increasing. And with the emergence of the virus causing the disease COVID-19, there is an urgency to expand the use of technology to help people who need routine care, and keep vulnerable beneficiaries and beneficiaries with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.

EXPANSION OF TELEHEALTH WITH 1135 WAIVER: 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.

Prior to this waiver Medicare could only pay for telehealth on a limited basis: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service.

Even before the availability of this waiver authority, CMS made several related changes to improve access to virtual care. In 2019, Medicare started making payment for brief communications or **Virtual Check-Ins**, which are short patient-initiated communications with a healthcare practitioner. Medicare Part B separately pays clinicians for **E-visits**, which are non-face-to-face patient-initiated communications through an online patient portal.

Medicare beneficiaries will be able to receive a specific set of services through telehealth including evaluation and management visits (common office visits), mental health counseling and preventive health screenings. This will help ensure Medicare beneficiaries, who are at a higher risk for COVID-19, are able to visit with their doctor from their home, without having to go to a doctor's office or hospital which puts themselves and others at risk.

TYPES OF VIRTUAL SERVICES:

There are three main types of virtual services physicians and other professionals can provide to Medicare beneficiaries summarized in this fact sheet: Medicare telehealth visits, virtual check-ins and e-visits.

MEDICARE TELEHEALTH VISITS: Currently, Medicare patients may use telecommunication technology for office, hospital visits and other services that generally occur in-person.

- The provider must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.
- It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

KEY TAKEAWAYS:

- ***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 same rate as regular, in-person visits.***
- ***Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.***
- ***While they must generally 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 Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.***
- ***The Medicare coinsurance and deductible would generally apply to these services. However, 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.***
- ***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.***

VIRTUAL CHECK-INS: In all areas (not just rural), established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation.

Medicare pays for these "virtual check-ins" (or Brief communication technology-based service) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would generally apply to 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 (HCPCS code G2010).

KEY TAKEAWAYS:

- ***Virtual check-in services can only be reported when the billing practice has an established relationship with the patient.***
- ***This is not limited to only rural settings or certain locations.***
- ***Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.***
- ***HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating 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; 5-10 minutes of medical discussion.***
- ***HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating 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.***
- ***Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.***

E-VISITS: In all types of locations including the patient's home, and in all areas (not just rural), 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. For these **E-Visits**, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

Medicare Part B also pays for E-visits or patient-initiated online evaluation and management conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes:

- 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
- 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
- 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

- G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
- G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
- G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

KEY TAKEAWAYS:

- ***These services can only be reported when the billing practice has an established relationship with the patient.***
- ***This is not limited to only rural settings. There are no geographic or location restrictions for these visits.***
- ***Patients communicate with their doctors without going to the doctor's office by using online patient portals.***
- ***Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.***
- ***The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable.***
- ***The Medicare coinsurance and deductible would generally apply to these services.***

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA): Effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive 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 COVID-19 nationwide public health emergency. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

Summary of Medicare Telemedicine Services

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses 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 inpatient) • 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* or established patients. *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
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.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99431 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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Medicare Telehealth Frequently Asked Questions (FAQs)
March 17, 2020

Q: How will recently enacted legislation allow CMS to utilize Medicare telehealth to address the declared Coronavirus (COVID-19) public health emergency?

A: The Coronavirus Preparedness and Response Supplemental Appropriations Act, as signed into law by the President on March 6, 2020, includes a provision allowing the Secretary of the Department of Health and Human Services to waive certain Medicare telehealth payment requirements during the Public Health Emergency (PHE) declared by the Secretary of Health and Human Services January 31, 2020 to allow beneficiaries in all areas of the country to receive telehealth services, including at their home.

Q: What does this mean? What payment requirements for Medicare telehealth services are affected by the waiver?

A: Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020.

Q: Why wasn't this done before?
A: Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. For example, the beneficiary receiving those services must generally be located in a rural area and in a medical facility. Where the beneficiary receives those services is known as the "eligible originating site." The beneficiary's home is generally not an eligible originating site, but under the new 1135 waiver, this will be waived during the emergency. This will now allow telehealth services to be provided in all settings – including at a patient's home.

Q: What services can be provided by telehealth under the new emergency declaration?

A: CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here: https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes. These services are described by HCPCS codes and paid under the Physician Fee Schedule. Under the emergency declaration and waivers, these services may be provided to patients by professionals regardless of patient location. Medicare pays separately for other professional services that are commonly furnished remotely using telecommunications technology without restrictions that apply to Medicare Telehealth. These services, including physician interpretation of diagnostic tests, care management services and virtual check-ins, are normally furnished through communication technology.

Q: Would physicians and other Qualified Providers be able to furnish Medicare telehealth services to beneficiaries in their homes?

A: Yes. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are in their homes or any setting of care.

Q: Who are the Qualified Providers who are permitted to furnish these telehealth services under the new law?

A: Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services

within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.

Q: Will CMS enforce an established relationship requirement?

A: No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Q: Is any specialized equipment needed to furnish Medicare telehealth services under the new law?

A: Currently, CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication they qualify as acceptable technology. The new waiver in Section 1135(b) of the Social Security Act explicitly allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive 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 COVID-19 nationwide public health emergency. For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/index.html

Q: How does a qualified provider bill for telehealth services?

A: Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Q: How much does Medicare pay for telehealth services?

A: Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

Q: Are there beneficiary out of pocket costs for telehealth services?

A: The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, 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.

Q: How long does the telehealth waiver last?

A: The telehealth waiver will be effective until the PHE declared by the Secretary of HHS on January 31, 2020 ends.

Q: Can hospitals, nursing homes, home health agencies or other healthcare facilities bill for telehealth services?

A: Billing for Medicare telehealth services is limited to professionals. (Like other professional services, Critical Access Hospitals can report their telehealth services under CAH Method II). If a beneficiary is in a health care facility (even if the facility is not in a rural area or not in a health professional shortage area) and receives a service via telehealth, the health care facility would only be eligible to bill for the originating site facility fee, which is reported under HCPCS code Q3014. But the professional services can be paid for.

Q: Can qualified providers let their patients know that Medicare covers telehealth?

A: Yes. Qualified providers should inform their patients that services are available via telehealth.

Q: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?

A: Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.

Q: How is this different from virtual check-ins and e-visits?

A: A virtual check-in pays professionals for brief (5-10 min) communications that mitigate the need for an in-person visit, whereas a visit furnished via Medicare telehealth is treated the same as an in-person visit, and can be billed using the code for that service, using place of service 02 to indicate the service was performed via telehealth. An e-visit is when a beneficiary communicates with their doctors through online patient portals.

Q: Are the telehealth services only limited to services related to patients with COVID-19?

A: No. The statutory provision broadens telehealth flexibility without regard to the diagnosis of the patient. This is a critical point given the importance of social distancing

and other strategies recommended to reduce the risk of COVID-19 transmission, since it will prevent vulnerable beneficiaries from unnecessarily entering a health care facility when their needs can be met remotely. For example, a beneficiary could use this to visit with their doctor before receiving another prescription refill. However, Medicare telehealth services, like all Medicare services, must be reasonable and necessary under section 1862(a) of the Act.

Q: Will CMS require specific modifiers to be applied to the existing codes?

A: CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

Q: What flexibilities are available in the Medicaid program to provide care via telehealth for individuals who are quarantined or self-isolated to limit risk of exposure?

A: States have broad flexibility to cover telehealth through Medicaid. No federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services. A state plan amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.

More information is available:
https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html