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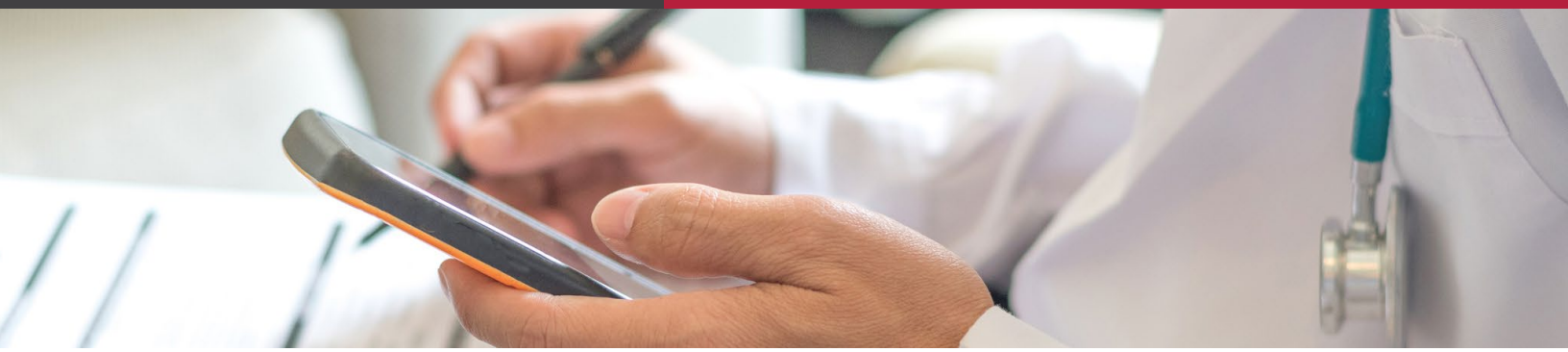
KEEPING A PULSE ON TELEMEDICINE CHANGES IN LIGHT OF COVID-19

by Jenny Givens
April 1, 2020



Providers of telemedicine services are reporting unprecedented surges in demand due to the global coronavirus pandemic. In addition to people's desire to limit potential exposure to the virus by visiting a doctor's office, much of this increase is due to the state and federal government's suspension of certain telemedicine restrictions.

TEXAS WAIVER

On Friday, March 13, Texas Governor Greg Abbott declared a "state of disaster" in response to the novel coronavirus pandemic and instructed state agencies to take action to make telemedicine readily available to the community. Per Governor Abbott's direction, the Texas Medical Board (TMB) issued a press release the following day informing the public that it is temporarily suspending certain provisions of the Texas Occupations Code and the Texas Administrative Code that place restrictions on practitioners' ability to use telemedicine in their treatment of patients.

Under typical circumstances, Texas Occupations Code Section 111.005 requires that a physician establish a valid physician-patient relationship through one of three methods if the physician wishes to render telemedicine services to a patient:

1. Have a pre-existing relationship with the patient;
2. Provide call coverage for another physician who has an established relationship with the patient; or
3. Provide telemedicine services to a patient with whom the physician does not have a prior relationship through technology that includes either:
    a. Synchronous (real-time, 2-way) audiovisual interaction between the practitioner and the patient; or
    b. Asynchronous store and forward technology in conjunction with real-time audio interaction between the practitioner and the patient, if the practitioner also uses clinical information from photographic images or video, including diagnostic images and the patient's relevant medical records (e.g., medical history and diagnostic test results); or
    c. Another form of audiovisual technology that allows the encounter to meet the standard of care.

To facilitate access to care and to avoid unnecessary exposure of healthcare providers and the public, the TMB is departing from its strict technology requirements and is now allowing a practitioner-patient relationship to be established through a telephone conversation and is allowing for the diagnosis and treatment of patients by phone. This suspension is in effect until the disaster declaration is lifted.

The TMB reminded practitioners that the laws and regulations related to standard of care have not changed—practitioners are required to provide services according to the same standard of care as if the services are provided in-person.

FEDERAL WAIVER

On March 6, 2020, the President signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 which, among other things, gives the Secretary of the Department of Health and Human Services (HHS) the authority to waive restrictions on the provision of telehealth services (commonly referred to as an 1135 waiver). The Centers for Medicare and Medicaid Services (CMS) issued a press release on March 17 announcing the expansion of telehealth benefits and allowing some flexibility with respect to how and where telehealth services may be rendered. Providers are encouraged to review the Telehealth Waiver FAQ and the General Provider Telehealth and Telemedicine Tool Kit issued by the CMS, which provides details about how providers may render telehealth services during this "Public Health Emergency (PHE)."

One of the initial modifications under the 1135 waiver that will have the most significant impact is CMS' coverage of telehealth services rendered to individuals in their homes. During the PHE, Medicare beneficiaries are no longer required to be located in

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a rural health area or travel to a physician's office or healthcare facility (i.e., an "originating site") to have their telehealth services covered. This opens the door for many who would not otherwise have telehealth benefits and, more importantly, keeps individuals who suspect they may have the virus in their homes thus limiting the risk of exposing others.

While CMS typically prohibits the waiver of any patient responsibility, in an effort to ensure that a Medicare beneficiary's financial position does not create a barrier to access, the HHS Office of the Inspector General (OIG) is permitting, if not encouraging, providers to waive the patient responsibility for telehealth services paid for by federal healthcare programs.

Medicare generally covers three types of virtual services: telehealth visits, virtual check-ins and e-visits. For ease of reference, physicians, advance practice nurses and physician assistants are collectively referred to as "practitioners".

Telehealth Visits
These services are similar to typical office and hospital visits but conducted through audio and video technologies. While CMS typically requires the practitioner and the patient to have an existing relationship to reimburse telehealth visits, CMS reports that HHS will not audit providers to ensure there was a prior relationship. With respect to the technology that may be used to render these services, unlike the TMB, which is allowing practitioners to render telehealth services by telephone without video capabilities, CMS currently will only cover evaluation and management telehealth visits if they are rendered using both audio and video capabilities allowing for "two-way, real-time interactive communication". In the 2008 Medicare Physician Fee Schedule, CMS adopted codes for certain evaluation and management services rendered solely by telephone. These codes were not considered to fall within CMS' definition of telehealth and were not considered a covered benefit. Recognizing the value of services that are not face-to-face during the PHE, CMS decided to reevaluate its reimbursement policies for several of these codes in its Interim Final Rule issued on March 30.

The HHS Office of Civil Rights (OCR) announced that it will exercise discretion in its enforcement of privacy and security requirements to allow practitioners to render telehealth services using common communications technologies such as Apple FaceTime, Skype, Facebook Messenger video chat and Google Hangouts video, which means almost all practitioners will have the technological capability of rendering telehealth services during the PHE. Practitioners must still make good faith efforts to protect patient privacy. Worth noting, Medicare will reimburse telehealth visits as it would an office visit and practitioners are permitted to bill retroactively for telehealth services rendered on or after March 6.

Virtual Check-Ins
Check-ins are essentially a brief communication between the patient and practitioner using telephone, secure email or text messaging, a patient portal and other similar methods of communication to determine whether the patient requires another service or an in-office visit. There are, however, some caveats-- virtual check-ins will only be covered by Medicare if (1) the patient and practitioner (or other practice member) have an established relationship; (2) the communication is not related to a medical visit that occurred within the prior 7 days and does not lead to a medical visit over the 24 hours following the check-in; and (3) the patient verbally consents to the virtual services.

E-Services
E-services are simply communications through a patient portal between a patient and practitioner who have an established relationship and are initiated by the patient. CMS published the below table which summarizes the parameters and codes for reimbursement.

Type of Service	Description of 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 visit) • G0425-G0427 (telehealth consultation, emergency department or initial inpatient) For a complete list: https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip	Not required to be an established patient during the PHE

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Virtual Check-in	A brief (5-10 min) check-in with a patient via telephones or other telecommunications decide to decide if an office visit or other service is necessary. A remote evaluation of recorded video and/or images submitted by a patient.	• HCPCS Code G2012 • HCPCS Code G2010	Not required to be an established patient during the PHE
E-Visits	A communication between a patient and provider through an online patient portal.	• 99431 • 99422 • 99423 • G2061 • G2062 • G2063	Not required to be an established patient during the PHE

**This is a limited list of codes and does not contain certain new codes added by the Interim Final Rule or the telephone-only evaluation and management codes (CPT 98966-98968 and 99441-99443). Check the CMS website for updates at: https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes.*

OTHER GUIDANCE AND CONSIDERATIONS

Reimbursement/Coverage

It is important to note that the waiver of laws and regulations related to telemedicine do not necessarily mean that all insurers will cover telemedicine or telehealth services. Providers will need to look to insurers' policies to determine whether they have relaxed their requirements for services rendered by telehealth. On March 17, the Texas Department of Insurance (TDI) issued an emergency rule requiring health benefits plans that are regulated by the TDI to reimburse contracted practitioners for the provision of a covered healthcare service via telehealth at the same rate as an in-person visit. Individuals whose health plans are regulated by TDI will have "TDI" or similar language printed on them. Keep in mind that if the patient has an employer-sponsored health plan, coverage may be different as these plans are not regulated by the TDI and benefits are dictated by the patient's employer and the federal government.

To encourage members to use telemedicine as a first line of defense, many insurers are waiving the patient responsibility for their members' urgent care needs. Aetna, for example, announced to its members that it will have a $0 copay for telemedicine services provided by its participating providers; however, it is not clear whether this would apply to providers who are not contracted with Aetna should they provide telemedicine services to Aetna members. As practitioners are well aware, no two payer policies are alike and all will have different requirements for coverage. The TDI created a helpful webpage that provides links to various Texas insurers' websites addressing coverage for testing and telemedicine services.

Coding Accuracy/POS Codes

As is always the case, practitioners must ensure their claims for reimbursement use the codes that most accurately represent the services that were rendered. Prior to the PHE, the CMS required practitioners to use place of service (POS) code 02 on claims for services rendered to Medicare beneficiaries via telehealth. When practitioners use POS code 02, CMS typically reimburses the practitioners at a slightly lower rate to take into account the facility fee paid to the originating site for its overhead. However, because the CMS is not requiring that patients present to an originating site during the PHE and the practitioner rendering telehealth services will have likely have additional overhead related to its provision of the telehealth services, the CMS is instructing practitioners to use the POS code that the practitioner would have used if the services were rendered in-person and to append modifier 95 to the claim line for the telehealth services to indicate the services were rendered via telehealth. Practitioners will need to check with insurers regarding their coding requirements as they may differ from the guidance provided by the CMS.

Prescribing Medications

Practitioners issuing prescriptions as the result of a telemedicine visit must ensure that the prescription is issued for a legitimate medical purpose as part of a practitioner-patient relationship and meet all other regulations related to the dispensing and delivering of dangerous drugs and controlled substances. Prior to the PHE, practitioners were prohibited from treating chronic pain (this prohibition does not apply to acute pain) via telemedicine. The TMB temporarily suspended this limitation to allow for telephone refills of valid prescriptions for the treatment of chronic pain. This suspension is in place until April 10, 2020, though an extension is anticipated. The Drug Enforcement Agency also placed limitations on the ability of practitioners to issue Schedule

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II-V controlled substances by telemedicine without first having an in-person visit, however, the Secretary of HHS designated that qualified practitioners may issue prescriptions for Schedule II-V drugs without an in-person visit throughout the duration of the PHE.

Supervision
Many services covered under the Medicare Physician Fee Schedule can be paid when provided under the supervision of a practitioner and not performed directly by the practitioner (i.e., services provided "incident to" the practitioner's services). In most cases, the CMS will only reimburse these services if rendered under the practitioner's direct supervision, which requires the practitioner be present in the office suite but not necessarily in the same room when the services are rendered. In its Interim Final Rule, the CMS noted that for the duration of the PHE, the CMS is altering the definition of direct supervision "to state that the necessary presence of the physician through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks to the beneficiary or healthcare provider.

Documentation
Practitioners must document visits in patients' medical records just as they would an in-person visit. Insurers could audit patient medical records down the road to determine whether the services were rendered and claims were appropriately paid. If the visit is not appropriately documented, payors may attempt to recoup payments.

Privacy & Security – Communications Platforms
Practitioners will need to keep in mind that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations, as well as state privacy and security laws, still apply. The OCR's notice of enforcement discretion is limited to allow practitioners to render telehealth services using common communications technologies such as Apple FaceTime, Skype, Facebook Messenger video chat and Google Hangouts video. The use of public facing telecommunications platforms such as TikTok, Facebook Live and Twitch is prohibited and most other HIPAA requirements are still in effect.

As all practitioners know, healthcare is complicated. While the CMS, the TMB and the TDI have made it much easier to render services through telecommunications, there are still a significant number of factors to be considered. Practitioners should also keep in mind that the laws, regulations and guidance related to telehealth are evolving quickly. If practitioners have questions regarding reimbursement or other aspects of telehealth, they should consult the applicable insurer's policy or contact their healthcare attorney for guidance.

ABOUT THE AUTHOR

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As a former hospital administrator, Jenny has a unique understanding of the challenges facing healthcare providers and the ins and outs of their business operations. Health systems, physicians and providers of ancillary services trust Jenny to help them navigate complex regulatory matters and, more importantly, to craft realistic solutions that they can operationalize. Jenny is Board Certified in Health Law by the Texas Board of Legal Specialization and Certified in Healthcare Compliance by the Compliance Certification Board.