TELEHEALTH COVERAGE POLICIES IN THE TIME OF COVID-19 TO DATE

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As things rapidly develop regarding what we know about COVID-19, policies around telehealth have also been developing alongside of it. Below is a summary of what is covered by various public and private payers with the information that has been released. Keep in mind that events are evolving and to consider this a living document that could change frequently as new information and new policies become available/are enacted. CCHP will continue to make updates when they become available.

Below is information regarding current policies and the changes made due to passage of HR 6074 and HR 748 as well as recently released CMS guidances. Note that HR 748 removed significant sections that HR 6074 had put into law.

MEDICARE FEE FOR SERVICE TELEHEALTH COVERAGE	
SUBJECT AREA	**CURRENT POLICY UNDER COVID-19**
Location of the Patient	Rural and site limitations are removed. Telehealth services can now be provided regardless of where the enrollee is located geographically and type of site, which allows the home to be an eligible originating site. Existing policies on facility fee prior to COVID-19 changes apply.
Eligible Services	Medicare expanded the list of eligible services provided via telehealth. For the list of codes, click HERE.
Eligible Providers	Changes in HR 748 added Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to the list of eligible providers **for this emergency period only**. The addition of FQHCs and RHCs is not a permanent change to the eligible provider list. • Physicians • Nurse practitioners • Physician assistants • Nurse-midwives • Clinical nurse specialists • Certified registered nurse anesthetists • Clinical psychologists (CP) • Clinical social workers (CSWs) (NOTE: CPs and CSWs cannot bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services. They cannot bill or get paid for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838). • Registered dietitians or nutrition professional • FQHCs/RHCs (during the emergency period only)
Modality	CMS clarified in their Final Interim Rule that for telehealth services a "telecommunications system" would mean "*multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.*"

Out-of-pocket costs/co-pays	Still applies, but the OIG is providing health care providers flexibility to reduce or waive fees.
Prior existing relationship to provide care via telehealth	Services via telehealth and remote patient monitoring and virtual check-in can be provided to new and established patients.
End Stage Renal Disease & Home Dialysis Patients	CMS exercising enforcement discretion on requirement that home dialysis patients receiving services via telehealth must have a monthly face-to-face, non-telehealth encounter in the first initial three months of home dialysis and after the first initial three months, at least once every three consecutive months. ESRD clinicians no longer must have one "hands on" visit/month for current required examination of vascular access site. Clinicians will not have to meet the National Coverage Determination or Local Coverage Determination of face-to-face visit for evaluations and assessments during this public health emergency.
Nursing Homes	CMS waiving requirement that physicians and non-physician practitioners perform in-person visit for nursing home residents and if appropriate, allow them to be done via telehealth.
Hospice	During an emergency period, the Secretary may allow telehealth to meet the requirement that a hospice physician or nurse practitioner must conduct a face-to-face encounter to determine continued eligibility for hospice care.
Frequency Limitations	The pre-COVID-19 frequency limitations on subsequent in-patient visit (once every three days), subsequent SNF visit (once every 30 days), and critical care consult (once a day) were removed.
Supervision	Physician supervision may be provided using live video. For other supervision changes, see CMS Provider and Practitioner Guidance.
Stark Laws	CMS allowing certain waivers: hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians; health care providers can support each other financially to ensure continuity of health care operations; and others. See CMS Physician and Practitioner Guidance.
Modifiers	Per the final interim rule, providers are allowed to report POS code that would have been reported had the service been furnished in person so that providers can receive the appropriate facility or non-facility rate and use the modifier "95" to indicate the service took place through telehealth. If providers wish to continue to use POS code 02, they may and it pays the facility rate.

Resources:

- CMS Fact Sheet
- CMS FAQ
- CMS Physician and Practitioner Guidance

Center for Connected Health Policy
The National Telehealth Policy Resource Center

- Interim Final Rule – Other changes were made in the Interim Final Rule that are not reflected in the overview charts on this page. See CCHP's crosswalk between the Interim Final Rule and the CMS Guidance document.

Other Medicare & Medicaid Policies

EXISTING TELEHEALTH POLICY PRE-COVID-19	POLICY CHANGE IN RESPONSE TO COVID-19	WHAT CAN BE COVERED
MEDICARE		
Licensing		
Temporarily waive Medicare and Medicaid requirements to be licensed in the patient state if they are enrolled in Medicare, have valid license in the state which relates to Medicare enrollment, in furnishing services in the state where there emergency is occurring, and not excluded from practicing in that state or any other state that is part of the emergency. State requirements will still apply.		
Medicare Advantage		
Medicare Advantage (MA) plans have the flexibility to have more expansive telehealth policies related to types of services covered, where those services can take place (no geographic or site limitations), modality used. Still limits the types of providers reimbursed.	Medicare Advantage Organizations were informed by CMS that if they wish to expand coverage of telehealth services beyond what has already been approved by CMS, they will exercise its enforcement discretion until it is determined that it is no longer necessary in conjunction with the COVID-19 outbreak. (CMS Memo)	MA plans have some flexibility to expand their coverage of telehealth beyond what they currently do. What is covered will depend on what each plan decides to do. NOTE: MA plans do **NOT** have to provide these more expansive telehealth services. They are only required to provide what is covered by Fee-for-Service.
Other Technology-Enabled Services		
Virtual Check-In Codes G2010, G2012* Can be done synchronously and asynchronously and telephone can be used	Other providers such as PTs, OTs and speech language pathologists may bill these codes as well as G2061-G2063.	Virtual check-in codes do not have geographic or site restrictions attached so they can be used to engage with patients, but the reimbursement amount for these codes is low and are only meant to act as quick check-ins with patients that do not last more than a few minutes.
Interprofessional Telephone/Internet/EHR Consultations (eConsult) * 99446, 99447, 99448, 99449, 99451, 99452	No Change Made	eConsult allows a provider-to-provider consultation. Pays both providers, but check definition for the time needed for each code.
Remote monitoring services: * Chronic Care Management Complex Chronic Care Management	No Change Made	These services are not considered "telehealth" services and were never subject to telehealth limitations. They do

Transitional Care Management Remote Physiologic Monitoring Principle Care Management		have other factors that limit how they can be used so make sure you check the definition for the codes.
Online Digital Evaluation (E-*Visit) – G2061-2063 Online medical Evaluations – 99421-99423	No Changes Made	These services are not considered "telehealth" services and were never subject to telehealth limitations.
Telephone E/M Services	Added by Interim Final Rule	98966-98968; 99441-99443
MEDICAID		
EXISTING TELEHEALTH POLICY PRE-COVID-19	**POLICY CHANGE IN RESPONSE TO COVID-19**	**WHAT WILL BE COVERED AT THIS TIME**
Telehealth reimbursement policies vary from state to state. If the State Medicaid program has managed care, telehealth reimbursement can vary from plan-to-plan. For Medicaid fee-for-service policies, check CCHP's website.	A Medicaid FAQ was issued stating that state Medicaid programs have broad authority to utilize telehealth within their Medicaid programs including using telehealth or telephonic consultations in place of typical face-to-face requirements when certain conditions are met. States would have to use the Appendix K process for this. As noted above, licensure requirements were waived for Medicaid, though state requirements would still apply.	Still developing. Some states have encouraged providers and health plans to utilize telehealth more broadly to provide services but for many states the policies continue to be developing as they navigate this situation.

Other Federal Actions

DEA

The declaration of the national emergency enacted one of the exceptions to the Ryan Haight Act for telehealth (telemedicine as it is referred to in the Act).

For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- *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.*

https://www.deadiversion.usdoj.gov/coronavirus.html

HIPAA

A change was made regarding the 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." https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/index.html

OCR Guidance - **https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html**

It should be noted that many states do have laws and regulations regarding health information and what is required to protect and secure it. This will likely not impact those state laws and regulations. A separate state action will be necessary.

PRIVATE INSURERS		
EXISTING TELEHEALTH POLICY PRE-COVID-19	**POLICY CHANGE IN RESPONSE TO COVID-19**	**WHAT WILL BE COVERED AT THIS TIME**
Coverage varied from payer-to-payer, depending on the plan.	Several health plans have announced that they will make telehealth more widely available or offering telehealth services for free for a certain period of time. Some of the announcements have come from Aetna, Cigna and BlueShield BlueCross. Additionally, Vice President Pence had announced that he had secured a commitment from the health plans to cover telehealth services, but no details or which plans had agreed were given.	Still developing. Few details have been given and would require individuals to inquire with their insurer what is exactly covered. Montana health plans recently agreed to cover telehealth delivered services. Check CCHP's State site for information. Some links to the announcements: Aetna Cigna BlueShield BlueCross

** See CCHP's Introductory Billing Guide to Medicare Fee-for-Service.*

FQHCS/RHCS – How can I use telehealth?

MEDICARE	MEDICAID	PRIVATE PAYER
With the passage of the CARES Act FQHCs and RHCs can act as both the originating or distant site for telehealth delivered services. FQHCs/RHCs will NOT be paid the PPS/AIR rate, but instead a methodology to	This will vary from state-to-state, with some states allowing FQHCs and RHCs to act as distant site providers, and some allowing them to receive their PPS rate, and others not. Some states prohibit FQHCs and RHCs	Will vary from payer-to-payer and state-to-state.

calculate a fee based upon fee-for-service will be created. FQHCs and RHCs can utilize some of the technology-enabled services to treat patients such as the virtual check-in and some of the chronic care management codes but not others like eConsult. An interim final rule, that allows FQHCs/RHCs to use online digital E/M codes for an established patient (99421-99423) was released. Click HERE for rule. However, final guidance from CMS on how these changes will be implemented has not been issued. For these technology-enabled codes, FQHCs and RHCs will receive a fee-for-service rate, not the PPS rate. FQHCs/RHCs are allowed to provide home nursing visits. Guidance HERE.	from acting as the distant site provider but may allow them to be originating sites. Other states are silent. Check CCHP's 50 State Report or your state Medicaid program.	

State Actions

For State Actions, go to CCHP's webpage for the latest information:

https://www.cchpca.org/resources/covid-19-related-state-actions