*(Last Updated 4/1/20)*

## COVID-19 Telehealth/Telemedicine Reimbursement Guide

For the duration of the COVID-19 crisis, Governor Sununu has issued emergency executive order #8 requiring all health plans authorized under RSA 5-B and New Hampshire Medicaid coverage, including all Medicaid Managed Care Organizations, to allow all in-network providers to deliver clinically appropriate, medically necessary covered services to members via telehealth. This includes all modes of telemedicine, including: video and audio, audio-only, and other media provided by medical providers.

All carriers shall ensure that rates of payment to in-network providers for services delivered via telehealth are not lower than the rates of payment established by the Carrier for services delivered via traditional (i.e. in-person) methods.

The NH Office of Licensure and Certification (OPLC) has issued a Telehealth Guidance: Exec. Order #8 Overrides Possible State Law Conflicts should questions arise with possible specific state law and administrative rule conflicts that may appear to arise from executive order #8.  Questions can be directed to Mike Padmore at michael.padmore@nhms.org or 603-858-4744.

**Current Guidance Temporarily Lifting Barriers to Telemedicine**

- **HIPAA** – For the duration of this emergency declaration, the US Department of Health and Human Services has indicated that it will waive HIPAA penalties for using non-HIPAA compliant videoconferencing software, allowing for popular solutions, such as Skype (basic) and FaceTime to be used to conduct telehealth sessions via video. This does **NOT** eliminate adherence to the other aspects of the law. The Office of Civil Rights has released further guidance about this.

- **Licensure** – Physicians providing telehealth services typically need a license in the state in which the patient is located at the time services are provided. However, through an executive order, Governor Sununu has authorized any out-of-state medical personnel, entering New Hampshire to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in RSA 21-P:41 and any other applicable statutory authority with respect to licensing for a period of time not to exceed the duration of this emergency.

- **E-prescribing Controlled Substances** – The DEA issued guidance providing greater flexibility that DEA-registered practitioners may issue prescriptions for all schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided that 1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice, and 2) the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.

  Interactive telemedicine and telephone assessments can be utilized by MAT (DATA-waivered) qualified practitioners prescribing buprenorphine products with a new patient for the treatment of opioid use disorders (OUDs).  However, in-person medical evaluations are still required for new OUD patients at methadone treatment clinics.

AMA's Special Coding Advice during COVID-19 Public Health Emergency resource PDF offers best coding practices for several COVID-19 (and non-COVID-19) clinical scenarios related to testing, telehealth visits, remote physiologic monitoring, virtual check-in or on-line visits via patient portal/e-mail (not related to E/M visit) or telephone call from qualified non-physician (those who may not report E/M).

The Medical Group Management Association (MGMA) has also developed a **COVID-19 coding cheatsheet** which provides resources for the relevant ICD-10-CM codes, CPT codes, HCPCS codes for COVID-19, as well as notes on telehealth technology and modifiers.

**Medicare** (UPDATED)

The Centers for Medicare and Medicaid Services (CMS) has issued a series of temporary regulatory waivers to further support the ability of the nation's healthcare system to respond to COVID-19 that allows patients to be seen via live videoconferencing in their homes, without having to travel to a qualifying "originating site" for Medicare telehealth encounters, regardless of geographic location.

When conducting a telemedicine encounter, you will use the same CPT codes as if the encounter were in-person, but with the Place of Service (POS) code 02 to indicate the care was provided via telemedicine.

Note that some private payers may ask for modifier 95, which indicates a telemedicine encounter, as well. You can access CMS's FAQ and additional fact sheets about what constitutes a telehealth encounter for reimbursement purposes, including:

- **New telehealth codes.** CMS will pay for 80 additional telehealth codes, including home visits, emergency department visits, and therapy services. Providers can waive copayments for all telehealth services for Original Medicare beneficiaries.

- **Virtual check-ins.** Clinicians can provide virtual check-in services (HCPCS G2012, G2010) to both new and established patients. Previously, these services were limited to established patients only.

- **Telephone codes.** CMS will reimburse for telephone evaluation and management services provided by a physician (CPT 99441-99443) and telephone assessment and management services provided by a qualified non-physician healthcare professional (CPT 98966-98968). These codes are only available to established patients but may be furnished using audio-only devices.

- **E-visits.** Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits (HCPCS G2061-G2063). These codes are only available to established patients and must be initiated by the patient.

- **Removal of frequency limitations on Medicare telehealth.** Subsequent inpatient visits (CPT 99231-99233), subsequent skilled nursing visits (CPT 99307-99310), and critical care consult codes (CPT G0508-G0509) no longer have limitations on the number of times they can be billed.

- **Medicare physician supervision requirements.** Physician supervision can be provided virtually using real-time audio/visual technology for services requiring direct supervision by a physician or other practitioner.

- **"Stark Law"** waivers**.** CMS is implementing waivers that exempt providers from sanctions for noncompliance of certain Stark Law rules, permitting certain referrals and the submission of related claims that would otherwise violate the Stark Law.

- **MIPS** flexibilities**.** CMS will allow clinicians adversely affected by COVID-19 to submit an application to request reweighting of the MIPS performance categories for the 2019 performance year.

- **Beneficiary Cost-sharing**. Ordinarily, the routine reduction or waiver of costs owed by Medicare beneficiaries, including coinsurance and deductibles, potentially implicate the Federal Anti-kickback Statute, the civil monetary penalty rule, and exclusion laws. The HHS Office of Inspector General (OIG) issued guidance stating it not subject physicians and other practitioners to OIG administrative sanctions for arrangements regarding reduced or waived cost-sharing for telehealth or other non-face-to-face services (i.e., virtual visits or evisits) during the COVID-19 public health emergency.

- **Beneficiary Consent**. Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time (i.e., not necessarily before) the time that services are furnished.

- **Medicare patients with ESRD**. Clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site. CMS is also exercising enforcement

discretion on the following requirement so that clinicians can provide this service via telehealth: Individuals must receive a face-to-face visit, without the use of telehealth, 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.

- **Nursing Home Residents**. CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

- **Telephone Calls**. The emergency declaration only applies to true telehealth encounters (e.g., live video/audio teleconferencing) and not phone calls without video. CMS is does allow providers to be reimbursed for patient-initiated "brief check-ins" via telephone, which last around 5 – 10 minutes.

| 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:<br>• 99201-99215 (Office or other outpatient visits)<br>• G0425–G0427 (Telehealth consultations, emergency department or initial inpatient)<br>• G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs)<br>For a complete list:<br>https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes | For new* or established patients.<br><br>*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<br>• HCPCS code G2010 | For established patients. |
| **E-VISITS** | A communication between a patient and their provider through an online patient portal. | • 99421<br>• 99422<br>• 99423<br>• G2061<br>• G2062<br>• G2063 | For established patients. |

### Medicaid (UPDATED)

As previously noted, executive order#8 requires New Hampshire Medicaid program, including all Medicaid Managed Care Organizations. An NH Medicaid Informational Bulletin (3/27/20) outlines enrolled eligible providers, eligible services covered, and reimbursement and billing to Medicaid patients via telemedicine, including video and audio, audio-only, or other media.

In brief, NH Medicaid pays the same rate as if the service was provided face- to- face. Billing for the service delivered should identify the CPT code(s) typically used for in-person visits with the addition of the GT modifier and place of service 02 (telehealth) to the claim form. NH Medicaid is not adopting a different set of procedure codes specific to telehealth. Examples are given in the informational bulletin.

Additionally, CMS approved New Hampshire's request for a Section 1135 waiver that allows Medicaid to:

- Reimburse otherwise payable claims from out-of-state providers not enrolled in New Hampshire Medicaid program if they meet the criteria outlined here.
- Temporarily suspend Medicaid fee-for-service prior authorization requirements.

**Private Insurance Carriers**

- **Anthem BC/BS New Hampshire**  (UPDATED)

  For 90 days effective March 17, 2020, Anthem's affiliated health plans will waive member cost shares for telehealth visits, including visits for mental health or substance use disorders, for our fully insured employer plans, Individual plans, Medicare plans and Medicaid plans, where permissible. Cost sharing will be waived for members using Anthem's authorized telemedicine service, LiveHealth Online, as well as care received from other providers delivering virtual care through internet video + audio services. Self-insured plan sponsors may opt out of this program.

  - o  For 90 days effective March 19, 2020, Anthem's affiliated health plans will cover audio-only visits with in-network providers. Out-of-network coverage will be provided where required. This includes covered visits for mental health or substance use disorders and medical services, for our fully insured employer plans, individual plans, Medicare plans and Medicaid plans, where permissible.

- **Cigna**  (UPDATED)

  Waive customer cost-sharing for office visits related to COVID-19 screening and testing through May 31, 2020 • Waive customer cost-sharing for telehealth screenings for COVID-19 through May 31, 2020 • Make it easier for customers to be treated virtually for routine medical examinations by in-network physicians • Provide free home delivery of up to 90-day supplies for Rx maintenance medications available through the Express Scripts Pharmacy and 24/7 access to pharmacists

- **Harvard Pilgrim HealthCare** (UPDATED)

  Beginning March 6, 2020, Harvard Pilgrim will not impose specific requirements on the type of technology that is used to deliver services (including any limitations on audio-only or live video technologies). These changes will be in place until further notice. Services may be reimbursed when all the following conditions are met:
  - o  Services rendered are clinically appropriate, medically necessary covered services.
  - o  The components of any E&M services provided via the telemedicine technologies includes at least a problem focused history and straight forward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual.
  - o  Providers performing and billing telemedicine/telehealth services are eligible to independently perform and bill the equivalent face-to-face service.
  - o  The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located.
  - o  The service is conducted and a permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record.
  - o  Services are filed with the appropriate modifiers and place of service codes. (See Billing Guidelines.)

- **Tufts Freedom Health Plan** (UPDATED)

  Tufts Health Plan will compensate providers at 100% of their contracted rate for services rendered, as specified in provider agreements. Effective for dates of services on or after March 6, 2020 until April 15, 2020, there are no restrictions on service type **for behavioral health providers**. Additionally, the usage of audio without video is acceptable.

## Choosing a Telemedicine/Telehealth Vendor

The Medical Society has also developed **Telemedicine/Telehealth Vendor Options Guide** that is a listing of telehealth/telemedicine vendors and other video conferencing options for clinical practices compiled by several state medical societies with brief summaries of each product, features and costs where available.

**How to Evaluate Telemedicine Vendors**

- Evaluate what you need for a telehealth/telemedicine services in your practice

  STEPS Forward on Telemedicine: Connect to Specialists and Facilitate Better Access to Care for Your Patients (0.5 credits CME)

  AMA's Digital Health Implementation Playbook

  MGMA's Telehealth Start-up Check List and Vendor Considerations

- Arrange demos with vendors that most closely align to your goals

- Ask for case studies and client referral list

- Schedule live vendor demos with select members of the core, advisory and implementation teams

- Evaluate vendors across six critical factors: Business, Information Technology, Security, Usability, Customer Service, and Clinical Validation (See Below)

- Narrow your options to one or two preferred vendors to include in your pitch to leadership

**6 Critical Factors CHECKLIST for Your Telemedicine Vendor Evaluation**

1) Business
   - ☐ Organizational overview – tenure, funding source, financial stability, affiliations, patients, etc.
   - ☐ Impact to program ROI – product cost, business model, reimbursement rates, risk sharing, support payment program participation, etc.

2) Usability
   - ☐ User experience of device and interface for patients and care team members
   - ☐ Patient and care team engagement metrics
   - ☐ Ability to engage with and encourage participation from patients
   - ☐ Degree to which this technology/vendor will reduce disruption to existing workflow

3) Information Technology
   - ☐ Ability to integrate with your current IT landscape, particularly your EHR system
   - ☐ Cost, process, and timeline associated with integration and product updates
   - ☐ Ensure the data elements of most importance to your clinicians and patients can be captured

4) Customer Service
   - ☐ Level of support available to practice during and after implementation—staff training, patient education, project management, data analysis and insights, etc.
   - ☐ Degree of technical support available to patients

5) Security
   - ☐ HIPAA compliance and process for ensuring protection of confidential patient information
   - ☐ Liability and process for managing potential security breaches

6) Clinical Validation
   - ☐ Documented clinical outcomes
   - ☐ Published peer-reviewed research