PROGRAM MATERIALS
Program #30148
June 2, 2020

Telehealth: Where We Were, Where We Are, And Where We Are Headed

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TELEHEALTH:
WHERE WE WERE,
WHERE WE ARE,
AND WHERE WE ARE HEADED

June 2, 2020 2:00 pm EST

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TELEHEALTH DEFINITIONS

TELEHEALTH GENERAL DEFINITIONS

- Most states have evolving statutes and regulations governing the definition of telehealth/telemedicine.
- Generally, telehealth consists of:
  - i. **Telemedicine**: Live, Two-Way Audiovisual Interactive Services
    - Examination, diagnosis, and treatment
    - Consultations
  - ii. **Store-and-Forward**
    - Electronic transmission between providers of a patient's medical data, such as digital images and video-exam clips, for assessment
    - Generally used for ophthalmology, dermatology, and radiology
  - iii. **Remote Patient Monitoring**
    - Electronic transmittal of medical data from patient to provider to treat and manage medical conditions that require frequent monitoring (e.g., congestive heart failure, diabetes, wound or ventilator care)

ROAD MAP

- State Licensure
- Corporate Practice of Medicine
- State Telehealth Practice Standard Laws
- Remote Prescribing
- HIPAA/Privacy Laws
- Fraud and Abuse Issues
- Reimbursement
  - Medicare
  - Medicaid
  - Private Payors
- Questions & Answers

STATE LICENSURE

LICENSURE – GENERAL RULES

- Providers must comply with state licensure requirements
  - State licensing laws generally require that providers be licensed by the state in which the patient is located
  - Full and unrestricted license is often required to render services directly to patients

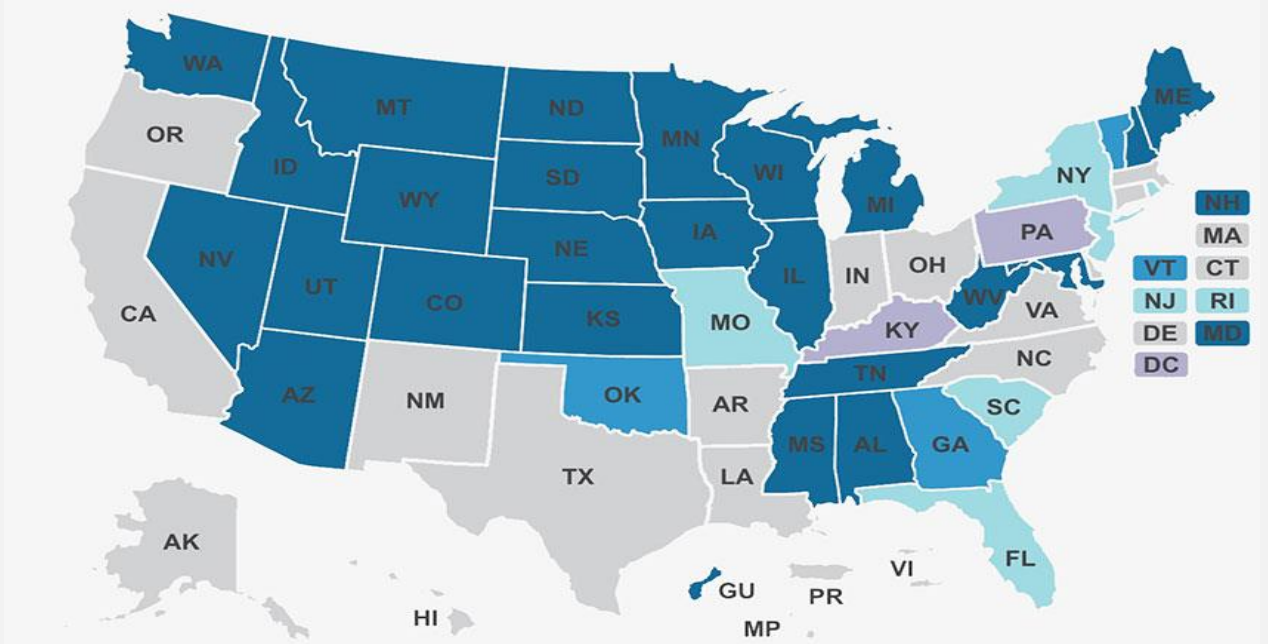
LICENSURE CHALLENGES

- Maintaining licenses in multiple states is an expensive, time consuming process that is often difficult to navigate
- The limited portability of licenses for healthcare professionals is a significant barrier for providers and can disincentivize the use of telemedicine to treat patients across state lines
    - Interstate Medical Licensure Compact created in an effort to address this legal hurdle

INTERSTATE MEDICAL LICENSURE COMPACT

- Voluntary agreement among the licensing boards of participating states
  - Allows physicians to practice medicine across state lines if eligibility requirements are satisfied
  - Streamlines and expedites the interstate licensure process

INTERSTATE MEDICAL LICENSURE COMPACT MEMBER STATES



STATE LICENSURE EXCEPTIONS

- Several states allow out-of-state providers to provide follow-up care to established patients
- Certain states offer limited licenses specific to telemedicine for out-of-state providers
- Other states have enacted reciprocity for bordering states
- State licensing laws generally permit the use of telemedicine for provider-to-provider consultations although some states limit to an “infrequent” or “irregular” basis

COVID-19 REGULATORY FLEXIBILITIES CMS 1135 WAIVER / PRACTITIONER LOCATIONS

- Effective March 1, 2020, through the end of the emergency declaration
- CMS is temporarily waiving requirements that out-of-state practitioners be licensed in the state where they are providing services when they are licensed in another state
- Waiver applies to Medicare and Medicaid
- Waiver does not impact state licensing requirements

COVID-19 REGULATORY FLEXIBILITIES STATE WAIVERS

- States retain authority over licensure
  - Reports of a blanket licensure waiver for all 50 states are inaccurate
- A number of states have temporarily loosened licensure restrictions and, to varying degrees, are allowing out-of-state providers to use telemedicine to see patients located in their respective state
  - E.g., New Jersey, Connecticut, Pennsylvania and Florida

WHAT WILL LICENSURE LOOK LIKE WHEN THE PUBLIC HEALTH EMERGENCY ENDS?

- Current licensure flexibilities are limited to the public health emergency period
- States will have to act to make emergency regulatory changes permanent

TELEMEDICINE PRACTICE STANDARDS

TELEMEDICINE PRACTICE STANDARDS

1. Establishing Physician-Patient Relationship
2. Modality of Communication Technology
3. Originating Site Restrictions
4. Patient-Site Telepresenter
5. Remote Prescribing Non-Controlled Substances
6. Remote Prescribing (Controlled Substances)
7. Medical Record-Keeping
8. Telehealth Informed Consent
9. Sharing Provider's Credentials and Contact Information
10. Special Telehealth Disclosures
11. Verifying the Patient's Identity and Location
12. Referrals for Emergency Services and/or Follow-up Care

TELEMEDICINE AND EVOLVING MODALITIES

Interactive Audio-Video

Asynchronous / Store & Forward

Interactive Audio w Store & Forward

Phone-only, form-based internet prescribing, AI

ASYNCHRONOUS/STORE AND FORWARD TELEMEDICINE

- Dynamic, intelligent questionnaires using clinical decision trees based on best practices and evidence-based medicine
- Incorporates clinically-relevant extrinsic medical information (e.g., photos, videos, diagnostic tests, labs, Bluetooth-enabled devices, prior medical records)
- Identifies the physician, creates a bona fide consult report and medical record, and allows for follow-up questions/instructions
- Medically-appropriate uses and emphasis on clinical protocols

ASYNCHRONOUS TELEMEDICINE BY THE NUMBERS

- ***12 states*** have laws that *expressly* ban asynchronous telemedicine to be used to establish a valid doctor-patient relationship, instead requiring the use of either audio-video or "interactive audio with store & forward" as the modality.
- ***15 states*** have laws that *expressly* allow asynchronous telemedicine to be used to establish a valid doctor-patient relationship.
- ***23 states*** do not mandate or proscribe a specific modality, instead choosing to more broadly define telemedicine to allow for new changes in technology and innovation (e.g., the use of secure electronic communications and information technologies between a patient at an originating site and a physician at a distant site).

Interpretive summary only; not legal advice; state laws are constantly evolving and state laws must be analyzed and applied to a specific clinical application.

COVID-19

- Modality Waivers
- Extends telemedicine practice to additional provider types
- Some states have suspended certain NPP supervision requirements

DELAWARE COVID-19 MODALITY WAIVERS

Pre-COVID

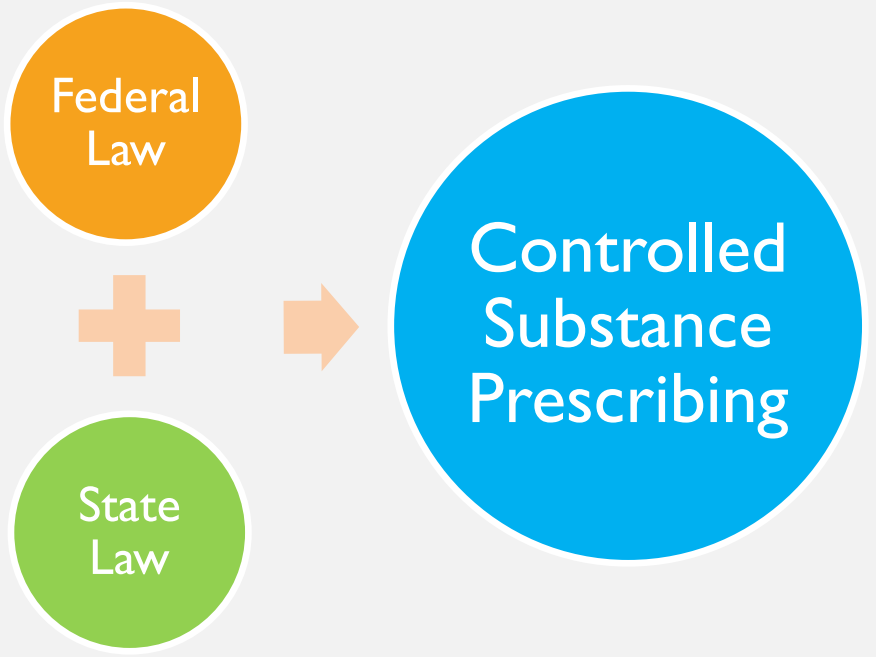
- **DE Board of Medical License and Discipline's Regulation: 24 Del. Admin. Code 1700-19.0:**
  - 19.3 For formation of the physician-patient relationship using audio and visual communications pursuant to 24 Del.C. § 1769D(h)(3), the audio and visual communications must be live, real-time communications.

COVID Waivers

- **Second Modification of the Declaration of a State of Emergency for the State of Delaware**
  - The requirement of an audio-video modality to establish the physician-patient relationship is waived.
- "*The Delaware Board of Medical License and Discipline's Regulation 19 regarding restrictions on the use of telemedicine is suspended.*"

REMOTE PRESCRIBING

REMOTE PRESCRIBING ISSUES



COVID-19

- Waivers on the state and federal level for non-controlled substances and controlled substances
- State:
  - Modality requirements for non-controlled substances
- Federal:
  - DEA registration waivers for controlled substance prescribing
  - Medication Assisted Treatment (MAT) Waivers
    - Modality
  - CSA: Ryan Haight Act Emergency Exception – 21 U.S.C. 829(e)
  - Medical Marijuana, MAT Prescribing

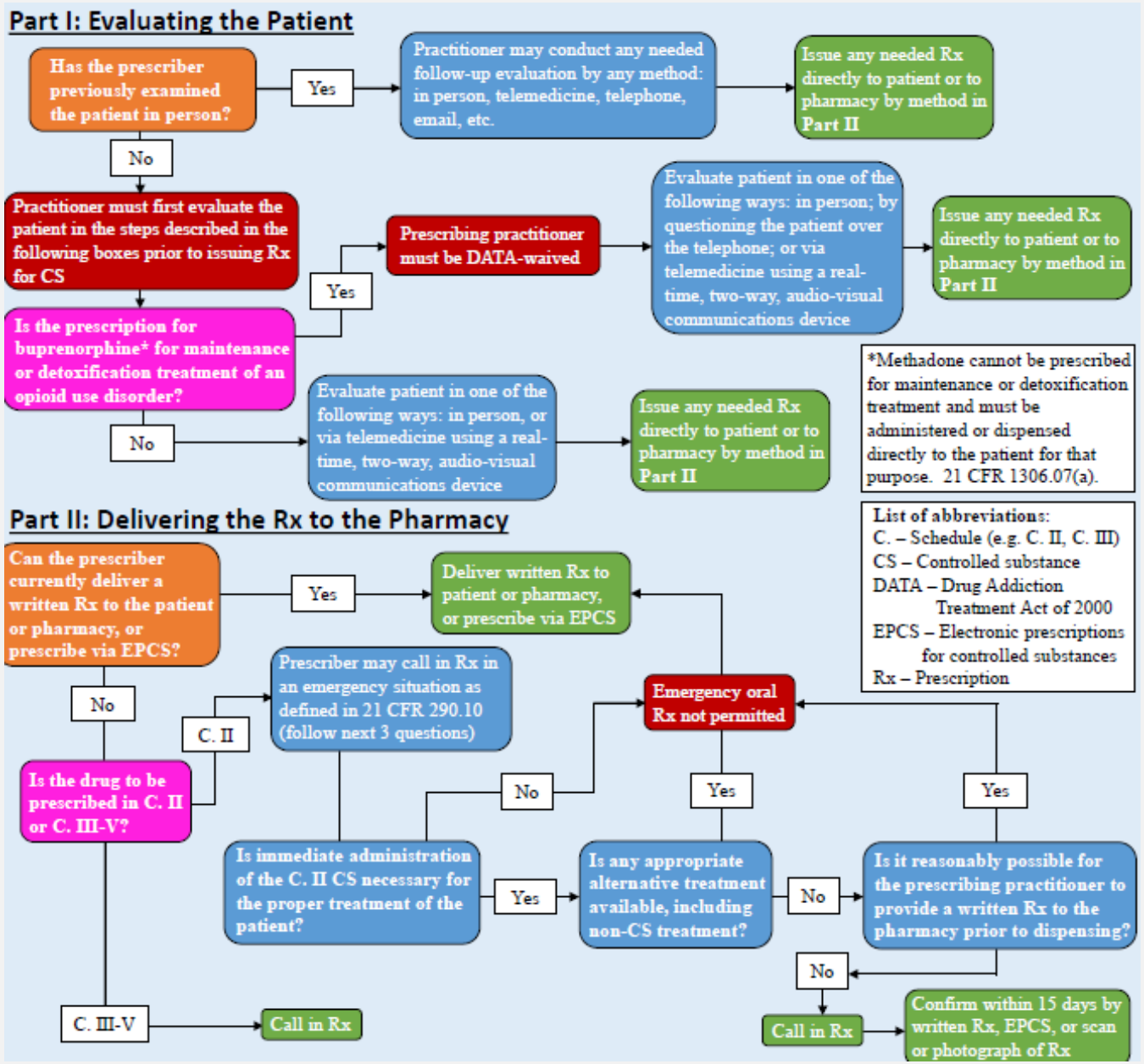
FEDERAL RYAN HEIGHT ACT: CONTROLLED SUBSTANCES

Pre-COVID

- **Ryan Haight Act: 21 U.S.C. 829(e)**
  - Requires a prior in-person examination in order to issue a "valid prescription" for a controlled substance
  - Exceptions

COVID Waivers

- **Public Health Emergency Exception 42 U.S.C. 247d (Jan. 31, 2020)**
  - Prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
  - Audio-visual, real-time, two-way interactive communication system; and
  - The practitioner is acting in accordance with applicable Federal and State laws.



DEA PRESCRIBING GUIDANCE

https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf

OHIO REMOTE PRESCRIBING

Pre-COVID

- Ohio physicians can only prescribe controlled substances via telemedicine if the physician meets all nine (9) factors for prescribing non-controlled substances under Rule 4731-11-9(D) and fits into one of the (6) six enumerated exceptions under Rule 4731-11-09(C).

COVID Waivers

- **State Medical Board of Ohio, Telemedicine, Emergency Licensure and Continuing Education Changes for State Medical Board of Ohio Licensees (Mar. 18, 2020):**
- Providers can use telemedicine in place of in-person visits, without enforcement from SMBO. This includes, but is not limited to:
  - Prescribing controlled substances
  - Prescribing for subacute and chronic pain
  - Prescribing to patients not seen by the provider
  - Pain management
  - Medical marijuana recommendations and renewals
  - Office-based treatment for opioid addiction

INDIANA CONTROLLED SUBSTANCES

Pre-COVID

- **Ind. Code Ann. § 25-1-9.5-8(b)-(c):**
  - Generally, an Indiana provider may not prescribe controlled substances via telemedicine, without an in-person exam, but there are some limited exceptions, including if an in-person examination is performed by an Indiana-licensed provider and a treatment plan is established to assist the prescriber, and other conditions.

COVID Waivers

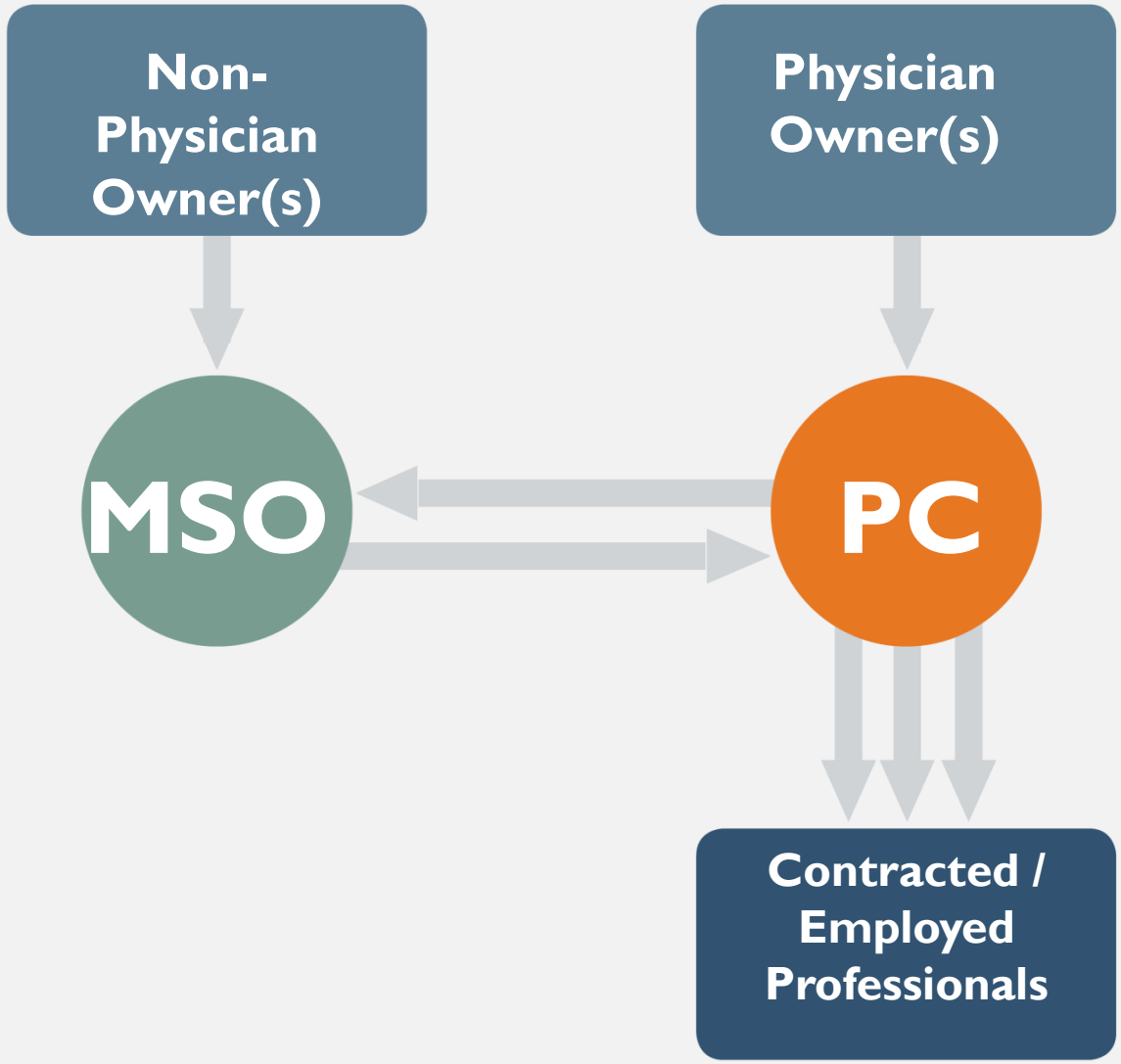
- **Executive Order 20-13 (March 30, 2020):**
  - Suspends Ind. Code section 25-1-9.5-8(b) and allows a prescriber who is also DEA-registered practitioner to issue prescriptions for all schedule II-V controlled substances for whom they have not conducted an in-person medical evaluation, provided: 1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of their professional practice; 2) the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system, and 3) all other applicable federal and state laws are followed.

CORPORATE PRACTICE OF MEDICINE

CPOM

- Some states maintain prohibition on direct ownership of a physician practice/medical group by non-physicians
- In states with a prohibition, only certain types of entities can employ / profit from physicians or certain types of health care providers
  - Exception: organize as a professional entity ("PC")
  - Separate clinical v. non-clinical responsibilities
  - Management services to the PC by the Management Entity ("MSO")
- Some states enforce prohibition more actively than others
- Many compliance considerations

"FRIENDLY" OR "CAPTIVE" PC MODEL



HIPAA/PRIVACY LAWS

HIPAA

Are you a covered entity?

HIPAA compliance includes:

- Compliant technologies
- Business Associate Agreements
- Risk Assessments
- Encryption
- Policies and procedures
- Training
- Limitations on the use and disclosure of PHI
- Distribution of Notice of Privacy Practices

COVID-19: OCR NOTIFICATION OF ENFORCEMENT DISCRETION

- Effective March 17, 2020
- OCR will exercise its enforcement discretion and will **not** impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
- Only non-public facing remote communication product (Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype).
- Applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

COVID-19: OCR NOTIFICATION OF ENFORCEMENT DISCRETION

- 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.

- Public facing products cannot not be used in the provision of telehealth by covered health care providers:
  - Facebook Live
  - Twitch
  - TikTok

OTHER PRIVACY LAWS

- State Laws
- Federal Laws governing specially protected information, such as substance abuse disorder records (Part 2 regs)
- If you are operating in the EU, remember the GDPR!

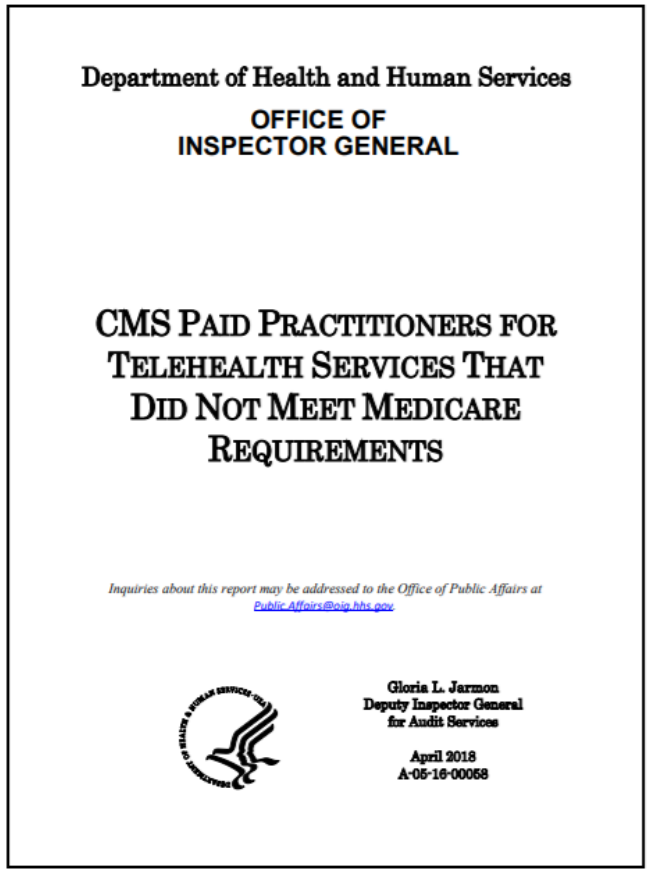
FRAUD & ABUSE ISSUES

FRAUD AND ABUSE

- False Claims Act
- Stark Law
- Anti-Kickback Statute
- Civil Monetary Penalty Law
- OIG Advisory Opinions

REIMBURSEMENT PITFALLS: OIG LESSONS LEARNED

- **April 2018 HHS-OIG Report – *CMS Paid Practitioners for Telehealth Services That Did Not Meet Medicare Requirements***
  - https://oig.hhs.gov/oas/reports/region5/51600058.asp
  - "Medicare paid a total of $17.6 million in telehealth payments in 2015, compared with $61,302 in 2001."
  - OIG's objective in the review was to determine whether CMS paid providers for telehealth services that met Medicare requirements.
  - OIG pulled a stratified random sample of 100 claims to determine whether services were reimbursable under Medicare.



Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

CMS PAID PRACTITIONERS FOR TELEHEALTH SERVICES THAT DID NOT MEET MEDICARE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

April 2018
A-05-16-00058

REIMBURSEMENT PITFALLS: OIG LESSONS LEARNED

- **What OIG found:**
  - 69 of 100 claims in OIG's sample met requirements for telehealth services.
  - 31 of 100 telehealth claims paid did not meet Medicare requirements:
    - beneficiaries received services at non-rural originating sites
    - claims were billed by ineligible institutional providers
    - services were provided to beneficiaries at unauthorized originating sites
    - services were provided by an unallowable means of communication
    - claims were for non-covered service
    - services were provided by a physician located outside of the U.S.

FALSE CLAIMS ACT (31 U.S.C. 3729 ET SEQ.)

- **Prohibits**
  - (1) submitting false claims for payment to U.S.
  - (2) submitting false statements in support of false claims
  - (3) improperly retaining funds to which U.S. is entitled (e.g., failing to repay overpayments)
- **Violation where party had actual knowledge, or acted with reckless disregard or deliberate ignorance, of falsity.**
- **Cases often initiated by whistleblowers under FCA's *qui tam* provisions.**
- **Violations can lead to sanctions and exclusion by HHS-OIG.**

ANTI-KICKBACK STATUTE ("AKS") 42 U.S.C. § 1320A-7B(B)

- Prohibits offering/giving anything of value to another person/entity to induce them to refer patients, to order goods/services, or to recommend the ordering of goods/services
- Prohibits requesting anything of value in exchange for referring patients, ordering goods/services, or recommending goods/services
- Various regulatory safe harbors can protect arrangements if strictly complied with (see 42 C.F.R. § 1001.952)
- Claims resulting from AKS violations are FCA violations

STARK LAW 42 U.S.C. § 1395NN

- Strict liability administrative law
- Prohibits financial relationships between physicians and entities to which they refer for inpatient and outpatient hospital and other specified services
- Prohibits billing of Medicare/Medicaid for services rendered to patients referred by physicians with prohibited relationships
- Violations render claims submitted to Medicare/Medicaid false, in potential violation of FCA

ENFORCEMENT RISK: RECENT EXAMPLES

- **Georgia Fraud Case** – JI Medical Inc., a DME provider, paid kickbacks to doctors who ordered medical equipment based on telemedicine consultations- but the consultations allegedly never occurred. Over 20 defendants charged and $470 million in fraud alleged.
- **February 8, 2019 OIG Self-Disclosure** – Highland Rivers Community Service Board, d/b/a Highland Rivers Health in Georgia agreed to pay $133,067.26 for allegedly violating the CMP Law by submitting or causing the submission of claims for psychiatric telehealth services provided to Medicare beneficiaries at certain Highland Rivers locations when the locations were not eligible for Medicare telehealth reimbursement because they were not "originating sites."
- **January 17, 2019 OIG Self-Disclosure -** Ironton-Lawrence County Community Action Organization, Inc., Ohio, agreed to pay $99,683.77 for allegedly violating the Civil Monetary Penalties Law. OIG alleged that Ironton-Lawrence submitted claims to Medicaid for telepsychiatry services from a service site that was not approved under Ironton-Lawrence's scope of project.

BLANKET WAIVERS OF SECTION 1877(G) OF THE SOCIAL SECURITY ACT DUE TO DECLARATION OF COVID-19 OUTBREAK IN THE UNITED STATES AS A NATIONAL EMERGENCY

- Effective March 1, 2020
- The blanket waivers apply only to financial relationships and referrals that are related to the national emergency that is the COVID-19 outbreak in the United States.
- Purpose:
  - (1) sufficient health care items and services are available to meet the needs of individuals enrolled in the Medicare, Medicaid, and CHIP programs;
  - (2) health care providers that furnish such items and services in good faith, but are unable to comply with one or more of the specified requirements of section 1877 of the Act and regulations thereunder as a result of the consequences of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent the government's determination of fraud or abuse:

COVID-19 WAIVER

- 18 Different Waivers, Including:
  - Remuneration from an entity to a physician (or an immediate family member of a physician) that is above or below the fair market value for services personally performed by the physician (or the immediate family member of the physician) to the entity.
  - Rental charges paid that are below fair market value for the entity's lease of office space from the physician (or the immediate family member of the physician).
  - Rental charges paid that are below fair market value for the entity's lease of equipment from the physician (or the immediate family member of the physician).
  - Remuneration from that is below fair market value for items or services purchased by the entity from the physician (or the immediate family member of the physician).
  - Remuneration from a hospital to a physician in the form of medical staff incidental benefits that exceeds the limit set forth in 42 CFR 411.357(m)(5).
  - Remuneration from an entity to a physician (or the immediate family member of a physician) in the form of nonmonetary compensation that exceeds the limit set forth in 42 CFR 411.357(k)(1).
  - Remuneration from an entity to a physician (or the immediate family member of a physician) resulting from a loan to the physician (or the immediate family member of the physician): (1) with an interest rate below fair market value; or (2) on terms that are unavailable from a lender that is not a recipient of the physician's referrals or business generated by the physician.

COVID-19 WAIVERS

A hospital pays physicians above their previously-contracted rate for furnishing professional services for COVID-19 patients in particularly hazardous or challenging environments.

To accommodate patient surge, a hospital rents office space or equipment from an independent physician practice at below fair market value or at no charge.

A hospital or home health agency purchases items or supplies from a physician practice at below fair market value or receives such items or supplies at no charge.

A hospital provides free use of medical office space on its campus to allow physicians to provide timely and convenient services to patients who come to the hospital but do not need inpatient care.

An entity provides free telehealth equipment to a physician practice to facilitate telehealth visits for patients who are observing social distancing or in isolation or quarantine.

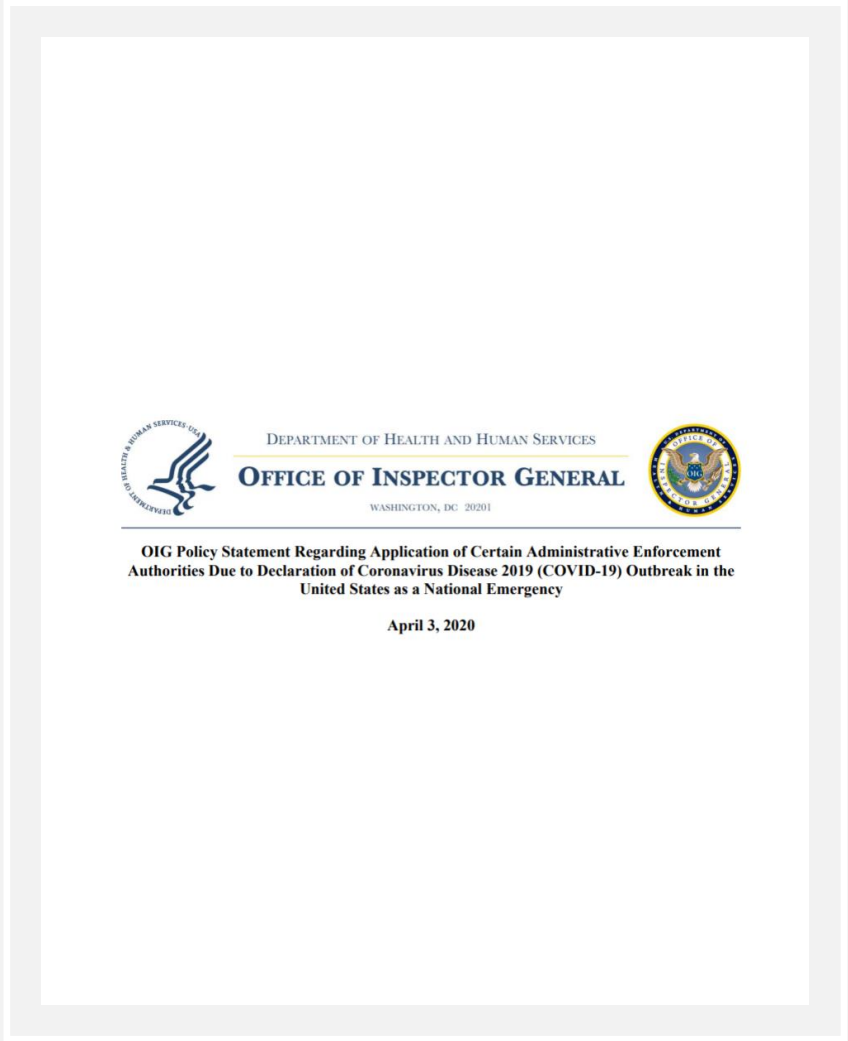
An entity sells personal protective equipment to a physician, or permits the physician to use space in a tent or other makeshift location, at below fair market value (or provides the items or permits the use of the premises at no charge).

A physician in a group practice whose principal medical practice is office-based orders radiology services that are furnished by the group practice to a Medicare beneficiary who is isolated or observing social distancing in the beneficiary's home, provided that the group practice satisfies all of the requirements of 42 CFR 411.352.

A hospital sends a hospital employee to an independent physician practice to assist with staff training on COVID-19, intake and treatment of patients most appropriately seen in a physician office, and care coordination between the hospital and the practice.

A hospital provides meals, comfort items (for example, a change of clothing), or onsite child care with a value greater than $36 per instance to medical staff physicians who spend long hours at the hospital during the COVID-19 outbreak in the United States.

An entity provides nonmonetary compensation to a physician or an immediate family member of a physician in excess of the $423 per year limit (per physician or immediate family member), such as continuing medical education related to the COVID-19 outbreak in the United States, supplies, food, or other grocery items, isolation-related needs (for example, hotel rooms and meals), child care, or transportation.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

OIG Policy Statement Regarding Application of Certain Administrative Enforcement Authorities Due to Declaration of Coronavirus Disease 2019 (COVID-19) Outbreak in the United States as a National Emergency

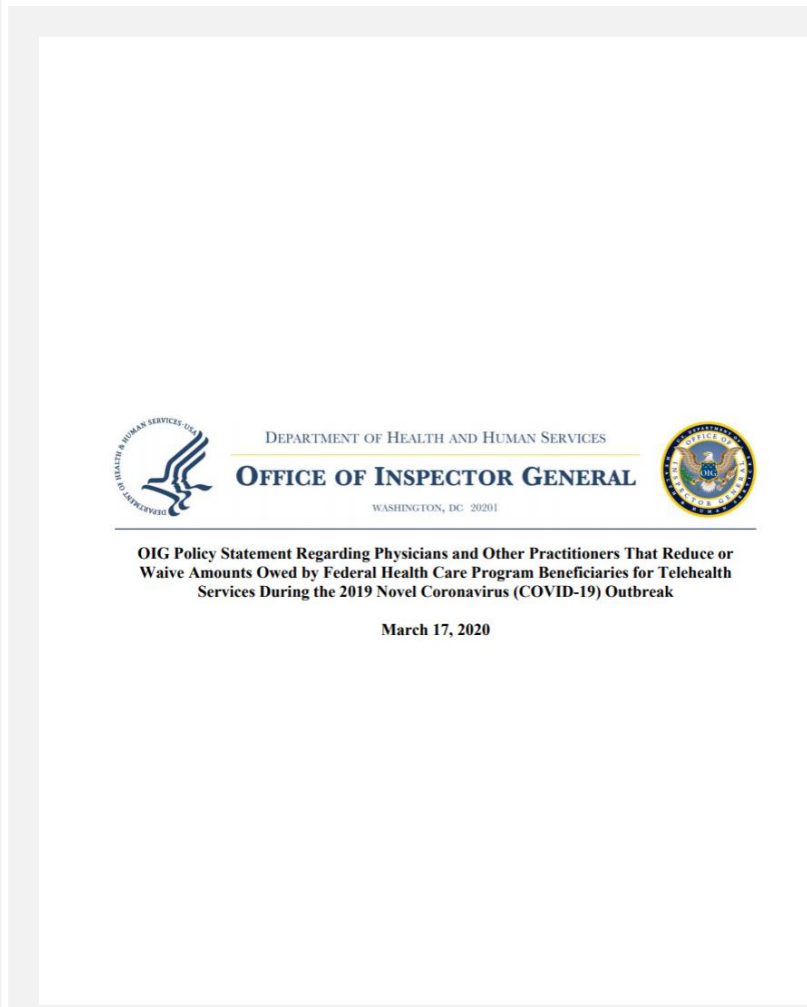
April 3, 2020

- Effective April 3, 2020
- In response to the unique circumstances resulting from the COVID-19 outbreak and the Secretary's COVID-19 Declaration, the Office of Inspector General (OIG) issues this Policy Statement to notify interested parties that OIG will exercise its enforcement discretion **not** to impose administrative sanctions under the Federal anti-kickback statute for certain remuneration related to COVID-19 covered by the Blanket Waivers of Section 1877(g) of the Social Security Act (the Act) issued by the Secretary on March 30, 2020 (the Blanket Waivers), subject to the conditions specified herein.

COVID-19 WAIVER FAQ

- Can a hospital provide access to its existing HIPAA-compliant, web-based telehealth platform for free to independent physicians on its medical staff to furnish medically necessary telehealth services during the time period subject to the COVID-19 declaration?

- According to the facts presented in the question we received, during the timeframe subject to the COVID-19 Declaration, the hospital would provide free access to a web-based telehealth platform to independent physicians on its medical staff.
- Limitations and conditions apply



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak

March 17, 2020

- Ordinarily, if physicians or practitioners routinely reduce or waive costs owed by Federal health care program beneficiaries, including cost sharing amounts such as coinsurance and deductibles, they would potentially implicate the Federal anti-kickback statute, the civil monetary penalty and exclusion laws related to kickbacks, and the civil monetary penalty law prohibition on inducements to beneficiaries.
- The policy statement notifies providers that OIG will **not** enforce these statutes if providers choose to reduce or waive cost-sharing for telehealth visits during the COVID-19 public health emergency, which the HHS Secretary determined exists and has existed since January 27, 2020.
- OIG intends for the Policy Statement to apply to a broad category of non-face-to-face services furnished through various modalities, including telehealth visits, virtual check-in services, e-visits, monthly remote care management, and monthly remote patient monitoring.

REIMBURSEMENT

SOURCES OF PAYMENT

- Medicare FFS*0110
- Medicare Advantage
- Medicaid (FFS, Managed Care)
- Commercial (Employer)
- Self-Pay

MEDICARE – DEFINITION OF TELEHEALTH SERVICES

- Limited coverage for traditional "telehealth services," which are paid at the same rate as though the service was performed in person.
- Section 1834(m)(4)(f) of the Social Security Act defines "telehealth services" as professional consultations, office visits, office psychiatry services, and any additional services specified by the Secretary.
- Section 1834(m) requires CMS to establish a process for adding or deleting services from the list of telehealth services payable under the Medicare Physician Fee Schedule on an annual basis.

MEDICARE – REIMBURSEMENT FOR TELEHEALTH SERVICES

In general, Medicare reimbursement for "telehealth services" is limited by:

Geography

Patient must be located in a Rural Health Professional Shortage Area located outside of a Metropolitan Statistical Area or in a rural census tract

Location of Patient

Patient must be located at a qualified facility (beneficiary's home is not an eligible originating site except for certain services)

Type of Provider

Limited to specific list of practitioners, authorized and credentialed at both the originating and distant sites

Technology

Interactive, audio-and-video telecommunications (real-time), except in federal telehealth demonstration programs in Alaska and Hawaii

MEDICARE – TELEHEALTH SERVICES DURING COVID-19

- Effective March 1, 2020 and for the duration of the COVID-19 public health emergency, Medicare has added over 80 services to the telehealth list and relaxed many limitations on reimbursement.
- In addition, CMS has announced that it will use a sub-regulatory process to modify the services included on the Medicare telehealth list during the COVID-19 public health emergency (rather than waiting to make changes to the telehealth list through the annual physician fee schedule rulemaking process). The periodically updated list of telehealth services will be available on the CMS website.

MEDICARE – TELEHEALTH SERVICES DURING COVID-19

Medicare will pay for telehealth services furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence.

Medicare will pay for telehealth services furnished using "mobile computing devices that include audio and video real-time interactive capabilities (i.e., a smart phone).

Medicare will pay for certain telehealth services furnished using audio-only telephone, when a beneficiary does not have access to audio-video communications equipment.

Medicare will pay for certain telehealth services furnished by any practitioner eligible to bill Medicare for their professional services, including PTs, OTs, and SLPs.

Medicare will pay for telehealth services at the same rate they would have paid for such services had they been delivered in person (i.e., telehealth services may be eligible to be billed at non-facility vs. facility rate).

Medicare will pay for subsequent inpatient visits, nursing facility visits, and critical care consultation services when furnished via Medicare telehealth without regard to frequency limitations.

Medicare will pay for required in-person, face-to-face clinical examinations for ESRD monthly capitation payments when furnished via Medicare telehealth.

MEDICARE – BEYOND "TELEHEALTH SERVICES"

- Effective January 1, 2019, the CMS CY 2019 Physician Fee Schedule significantly expanded coverage for certain "communication technology-based services."
- CMS does not consider these services to be "telehealth services," as described in previous slides.
- Accordingly, the statutory restrictions for reimbursement do not apply to these services, even though they may utilize telecommunications technology.

MEDICARE – VIRTUAL CHECK-INS

- **HCPCS Code G2012** covers brief (5-10 min), non-face-to-face check-ins with a patient via communication technology, to assess whether the patient's condition requires an office visit.
  - Must be provided to an established patient by a physician or other provider who can report E/M services.
  - Cannot originate from a related E/M service provided within the previous 7 days, nor lead to an E/M service within the next 24 hours or soonest available appointment.
  - May be performed via audio-only, real-time telephone interactions or synchronous two-way audio interactions enhanced with video or other kinds of data transmission.
  - Must obtain patient's verbal consent annually

MEDICARE - REMOTE EVALUATION OF PRE-RECORDED INFORMATION

- **HCPCS Code G2010** covers the remote evaluation of recorded video and/or images and subsequent communication time with patient within 24 hours.
  - Images must be submitted by an established patient.
  - Cannot originate from a related E/M service provided within the previous 7 days, nor lead to an E/M service within the next 24 hours or soonest available appointment.
  - Follow-up communication with patient can occur via audio/video, phone, secure text messaging, email, or patient portal communications.
  - Must obtain patient's verbal consent annually.

MEDICARE - INTERPROFESSIONAL INTERNET COMMUNICATIONS

- **CPT Codes 99446-99449, 99451, 99452** cover interprofessional internet communications provided by a consultative health care professional.
  - Covers consultations between health care professionals resulting in a verbal and written report to the patient's treating/requesting provider (no direct patient contact with consulting provider).
  - Requesting health care professional must obtain verbal consent from the patient annually.

MEDICARE – CTBS DURING COVID-19

Medicare will pay for CTBS (G2010 and G2012) furnished to both new and existing patients.

Medicare will allow the required annual beneficiary consent to receive CTBS to be obtained at the same time the services are furnished either by the billing practitioner or by state under general supervision.

Medicare will pay for CTBS furnished by additional practitioners who do not report E/M codes, including PTs, OTs, SLPs, LCSWs, and LCPs

MEDICARE – ONLINE DIGITAL EVALUATIONS

- **CPT Codes 99421, 99422, 99423, G2061, G2062, G2063** cover online digital evaluation ("e-visit") services, which generally include non-face-to-face patient initiated communications through an online patient portal.

MEDICARE – E-VISITS DURING COVID-19

Medicare will pay for e-visits furnished to both new and existing patients.

Medicare will pay for e-visits furnished by additional practitioners who do not report E/M codes, including PTs, OTs, SLPs, LCSWs, and LCPs

MEDICARE – REMOTE PATIENT MONITORING SERVICES

- **CPT Codes 99091, 99453, 99453, 99,457, 99458, 99473, 99474** cover separately billable (i.e., unbundled) remote patient monitoring and chronic care remote physiologic monitoring services.

MEDICARE – RPM SERVICES DURING COVID-19

Medicare will pay for RPM services furnished to both new and existing patients.

Medicare will allow the required beneficiary consent to be obtained once annually, including at the same time the services are furnished.

Medicare will pay for RPM services provided for both acute and chronic conditions.

Medicare will allow RPM services to be reported for periods of time that are fewer than 16 of 30 days, but no less than 2 days, for patients who have a suspected or confirmed diagnosis of COVID-19, as long as the other requirements for billing the codes are met.

MEDICARE – TELEPHONE E/M SERVICES DURING COVID-19

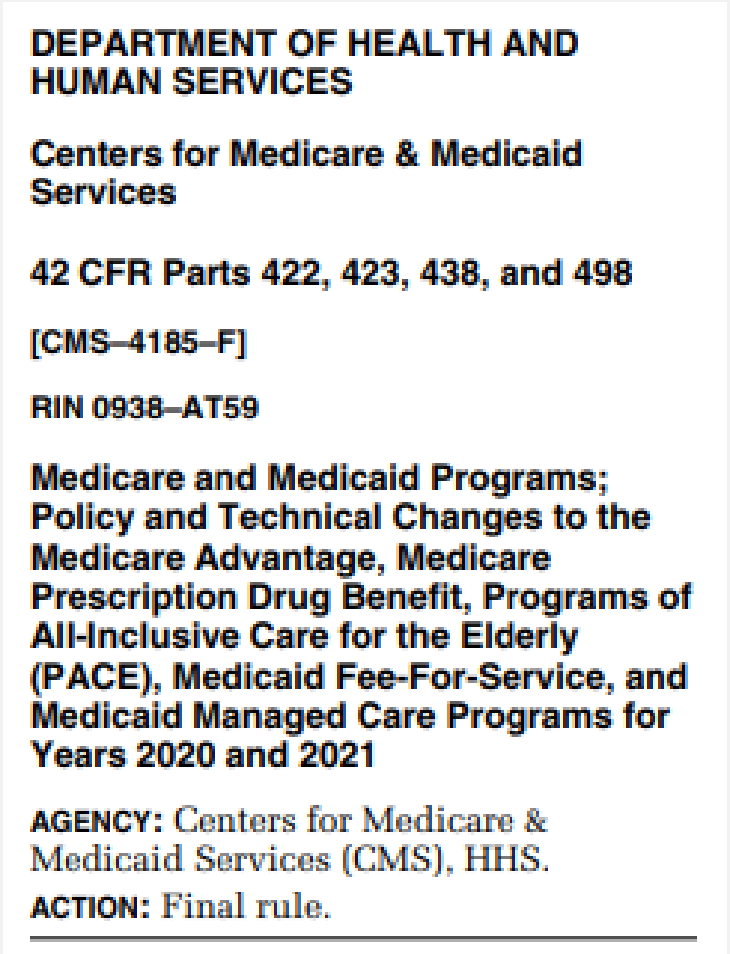
- During the COVID-19 public health emergency, Medicare separately pays for **CPT Codes 98966, 98967, 98968, 99441, 99442, 99443**, which cover separately billable telephone evaluation and management services.
  - Codes may be used for both new and established patients.
  - Medicare will pay for telephone E/M services furnished by additional practitioners who do not report E/M codes, including PTs, OTs, SLPs, LCSWs, and LCPs.
  - Reimbursement rates were recently increased to match payment rates under the PFS for office/outpatient visits with established patients.

MEDICARE ADVANTAGE - OVERVIEW

- Medicare Advantage plans are able to voluntarily provide coverage for more telehealth services than are currently payable under original Medicare as "supplemental benefits" (MA plans not limited by the original Medicare statutory limitations for telehealth services).
- Supplemental benefits are paid for using rebate dollars or supplemental premiums paid by enrollees. The extent to which specific telehealth services are covered varies by plan.
- In 2018, 81 percent of MA plans offered supplemental telehealth benefits.

MEDICARE ADVANTAGE – IMPROVED FLEXIBILITY IN 2020

- April 16, 2019 Final Rule authorizes MA plans to provide "additional telehealth benefits" to enrollees starting in plan year 2020 and treat them as basic benefits.
- Basic benefits are structured and financed based on what is covered under Medicare Parts A and B and are accounted for in the capitated payment that Medicare makes to the MA plan.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 422, 423, 438, and 498

[CMS–4185–F]

RIN 0938–AT59

Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

MEDICARE ADVANTAGE – IMPROVED FLEXIBILITY IN 2020

- Additional telehealth benefits = those services that are
  - covered by Medicare Part B but do not meet specific statutory requirements for telehealth coverage; and
  - are identified by the MA plan for the applicable year as clinically appropriate to be furnished through "electronic exchange."
- All other services can still be offered as "supplemental benefits."
- **"While MA plans have always been able to offer more telehealth services than are currently payable under original Medicare through MA supplemental benefits, this change in how such MA additional telehealth benefits are financed (that is, accounted for in the capitated payment) makes it more likely that MA plans would offer them and that more enrollees would use the benefit."** 84 Fed. Reg. at 15,683 (MA Final Rule, April 16, 2019)
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MEDICARE ADVANTAGE – TELEHEALTH COVERAGE DURING COVID-19

- CMS is exercising enforcement discretion to allow Medicare Advantage plans to expand telehealth services and other mid-year benefit enhancements beyond those included in their approved 2020 benefits when such benefits are:
  - provided in connection with the COVID-19 outbreak;
  - beneficial to enrollees; and
  - provided uniformly to all similarly situated enrollees.

MEDICAID – COVERAGE FOR TELEHEALTH SERVICES

- Medicaid reimbursement for telehealth services varies by state (states have a lot of flexibility).
- States may offer Medicaid telehealth benefits on a fee-for-service (FFS) basis, through managed care plans, or both.
  - FFS – State pays providers directly for each covered services.
  - Managed Care – State pays a fee to a managed care plan for each person enrolled in the plan, and the plan pays for all of the Medicaid services provided to the beneficiary.

MEDICAID – COVERAGE FOR TELEHEALTH SERVICES

- Key items to consider:
  - Does the state Medicaid program provide reimbursement for telehealth services?
  - Are telehealth services covered at the same rate as in-person services?
  - Does the state limit who can provide telehealth services or who can receive telehealth services?
  - Does the state impose other limitations on coverage, such as type of patient (new vs. established), modality requirements, and location requirements?

MEDICAID – TELEHEALTH COVERAGE DURING COVID-19

- Many states have enacted temporary waivers or permanently expanded Medicaid coverage of telehealth services. These waivers vary by state.
- CMS has issued the 1135B waivers discussed above regarding licensure and practitioner locations
- CMS also released a "State Medicaid & CHIP Telehealth Toolkit" with policy considerations for states expanding use of telehealth.

COMMERCIAL COVERAGE FOR TELEHEALTH SERVICES

- Varies greatly by plan/insurer.
- Some requirements mandated at the state level through commercial payer statutes that address telehealth coverage
  - Coverage parity
  - Payment parity
  - Restrictions on type of service covered (modality, originating site)

COMMERCIAL PAYORS – TELEHEALTH COVERAGE DURING COVID-19

- Many states have adopted private payer legislation or issued guidance to facilitate or, in some cases, mandate private payer reimbursement for telemedicine services during the COVID-19 public health emergency.
  - Expansion of types of services covered (e.g., telemental health services)
  - Expansion on types of modalities covered (e.g., asynchronous or audio-only)
  - Waivers on requirements for in-person assessments or established patient requirements.