Medicare Telehealth/Telemedicine Waivers During the COVID-19 Public Health Emergency

-Last Updated May 1, 2020[1]-

The Department of Health & Human Services (HHS) has instituted several flexibilities that waive many of the generally applicable rules governing Medicare telehealth services in response to the COVID-19 public health crisis. These flexibilities have been implemented incrementally, however this resource intends to provide a comprehensive overview of all telehealth and telemedicine waivers issued to date. Please keep in mind that this resource addresses Medicare payment policy, and that Medicaid and commercial payers may institute their own payment rules.

For more information, please contact MGMA Government Affairs at govaff@mgma.org or 202.293.3450. For the latest COVID-19 developments impacting medical practices and information on waivers of other Medicare rules, visit the MGMA COVID-19 Action Center.

Telehealth

Under Medicare payment policy, "telehealth" is a term of art that refers to services that would ordinarily be furnished in person (i.e., office visits, E/M services), but are instead furnished remotely. **Under ordinary circumstances, the following rules apply to Medicare telehealth services:**

1. The service must be furnished via an interactive telecommunications system **("modality")**;
    - Interactive telecommunications system means 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. Telephones, facsimile machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.
2. The service must be furnished by a physician or other authorized practitioner **("distant site practitioner")**;
3. The individual receiving the service must be located in a telehealth originating site, which generally must be a clinical site of service, such as a physician office, critical access hospital (CAH), hospital, SNF, or community mental health center **("qualifying originating sites")**;
4. The qualifying originating site must be located in certain geographic areas, such as a health professional shortage area within rural census track **("geographic limitation")**; and
5. The service must be on the list of covered codes **("covered codes").**

Waivers to Traditional Telehealth Billing Requirements

Modality:

[1] Disclaimer: Information provided by MGMA within this resource is for guidance purposes only. It does not constitute clinical or legal advice and does not address or dictate payer coverage or reimbursement policy.

While the Centers for Medicare & Medicaid Services (CMS) has implemented several flexibilities around Medicare telehealth services during the COVID-19 public health crisis, the Agency continues to require that most Medicare telehealth services be furnished using devices or telephones that have audio ***and*** video capabilities. Healthcare clinicians *may* use a telephone, so long as it has audio and video capabilities that are used for two-way, real-time interactive communication.

Update May 1: CMS is permitting use of audio-only equipment to furnish a select number of services, such as audio-only telephone E/M services (CPT codes 99441-99443 and 98966-98968) and behavioral health counseling and educational services. Unless provided otherwise, other services included on the Medicare telehealth services list must be furnished using, at a minimum, audio and video equipment. Services that may be furnished using audio-only modalities are marked as such in the list of Medicare telehealth services, which can be accessed here.

Distant Site Practitioner:

Qualified healthcare professionals may furnish telehealth services from their own home (i.e., they are not required to be at their office when furnishing telehealth to patients). Specifically, CMS states that: "There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their homes."

While previous guidance required that providers furnishing telehealth services from their homes update their enrollment files to reflect their home address, CMS recently relaxed this requirement and now provides the following billing guidance: "The practitioner is not required to update their Medicare enrollment with the home location. The practitioner should list the home address on the claim to identify where the services were rendered. The discrepancy between the practice location in the Medicare enrollment (clinic/group practice) and the practice location identified on the claim (provider's home location) will not be an issue for claims payment."

Update May 1: CMS is waiving the requirements that specify the types of practitioners that may bill for Medicare telehealth services from the distant site. The waiver of these requirements expands the types of healthcare professionals that can furnish telehealth services to include all those that are eligible to bill Medicare for their professional services. This allows health care professionals who were previously ineligible to furnish and bill for Medicare telehealth services, including physical therapists, occupational therapists, speech language pathologists, and others, to receive payment for Medicare telehealth services. [2]

Qualifying Originating Sites:

Originating site restrictions are waived, permitting clinicians to furnish services to patients that are in their homes or other locations.

Geographic Limitations:

Geographic limitations are also waived, permitting clinicians to furnish services to patients located in any geographic area of the country, regardless of whether it is rural, urban, etc.

[2] Emergency Declaration Waivers.

Covered Codes:

Update May 1: CMS expanded the list of ordinarily covered codes to now include more than 100 additional codes during the public health emergency, including several new codes that were added as of April 30. The full list of codes eligible for telehealth are listed here.

Additional Applicable Waivers

Licensing:

CMS has temporarily waived the requirement that physicians or other healthcare professionals hold licenses in the state in which they provide services if the following four conditions are met:

1) The physician or nonphysician practitioner must be enrolled as such in Medicare;
2) The physician or nonphysician practitioner must possess a valid license to practice in the State that relates to his or her Medicare enrollment;
3) The physician or non-physician practitioner is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and
4) The physician or non-physician practitioner is not affirmatively excluded from practice in the State or any other State that is part of the emergency area.

This waiver does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government. Those requirements would continue to apply unless waived by the State.

HIPAA:

The HHS Office for Civil Rights (OCR) will waive penalties under HIPAA violations against healthcare providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype. OCR advises that providers should not use modalities that are public facing, such as Facebook Live or Tik Tok.

Beneficiary Cost-sharing:

Ordinarily, the routine reduction or waiver of costs owed by Medicare beneficiaries, including co-insurance 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 will *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 e-visits) 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.

Removal of Frequency Limitations:

The following services no longer have limitations on the number of times they can be provided by Medicare telehealth:

- A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);

- A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310); and
- Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

End Stage Renal Disease (ESRD) Services:

For 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.

Telehealth Billing Guidelines

Place of Service:

During the COVID-19 pandemic, telehealth services billed to Medicare should be billed using the place of service (POS) code that would have been reported had the service been furnished in person. For example, a physician practicing in an office setting who sees patients via telehealth, instead of in person, would report POS-11-Office. Additionally, the telehealth modifier (modifier 95) should be applied to claim lines that describe services furnished via telehealth.

In ordinary circumstances, billing guidance instructs providers to use the POS-02-Telehealth code to indicate the billed service was furnished as a telehealth service from a distant site. Telehealth services identified using POS-02 are paid at the physician fee schedule (PFS) facility rate because CMS believes the facility costs (clinical staff, supplies, and equipment) associated with the service would generally be incurred by the originating site, where the patient is located, and not by the practitioner at the distant site.

Now, during the COVID-19 pandemic, CMS recognizes that physician practices are transitioning a potentially significant portion of their services from in-person to telehealth visits during the COVID-19 pandemic, while still incurring resource costs just as they would if services were still furnished in person. The effect of this policy is that practitioners may bill their ordinary POS code and may receive payment for telehealth services using the PFS non-facility rate, which is often higher than the facility rate.

CMS states that practices may continue to use POS-02-Telehealth "should [they] choose, for whatever reason," but will be paid using the lower facility payment rate.

Reporting of E/M Visit Level:

For the duration of the public health emergency, CMS will permit reporting of telehealth E/M office or other outpatient visits based on either (1) time, which is defined as all of the time associated with the

E/M on the day of the encounter; or (2) Medical Decision Making (MDM). CMS is not requiring history or exam to be used in selecting an E/M service via telehealth.

This temporary policy is similar to the policy that will apply to all office/outpatient E/M services beginning in 2021 under policies finalized in the CY 2020 PFS final rule.[3]

Audio-only E/M Codes (99441-99443; 98966-98968)

CMS will reimburse for audio-only telephone E/M visits using CPT codes 99441-99443 and 98966-98968. These codes were not previously reimbursed by Medicare but are covered for the duration of the public health emergency to reimburse for cases where the two-way, audio and video technology required to furnish a Medicare E/M service is unavailable.

Modality:

CPT codes 99441-99443 and 98966-98968 can be furnished using ***audio-only*** modalities, such as an audio-only telephone call.

Qualifying Patients:

These services can be furnished to both new and established patients, even though the codes are intended for established patients only and their code descriptors reflect this. During the public health emergency, CMS is exercising enforcement discretion to relax enforcement of this aspect of the code descriptors.

Qualifying Practitioners:

- CPT codes 99441-99443 describe telephone evaluation and management services by *a physician or other qualified healthcare professional who may report E/M services.*
- CPT codes 98966-98968 describe telephone assessment and management services by *a practitioner who cannot separately bill for E/M services.* CMS elaborates that this means the codes "may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners."[4]
- These are time-based codes that describe 5-10 minutes of medical discussion (99441/98966); 11-20 minutes of medical discussion (99442/98967); 21-30 minutes of medical discussion (99443/98968).

National Valuation of the Codes:

Update May 1: Following MGMA advocacy, CMS is increasing payment for audio-only telephone E/M services (CPT codes 99441-99443) such that they are paid at the same rate as similar office and outpatient E/M visits, resulting in increased payments from $14-$41 to $46-$110 (e.g., to be consistent with payment rates for level 2-4 established office/outpatient E/M visits).[5] CMS is not increasing

[3] CMS First Interim Final Rule (IFR) (Mar. 26, 2020), page 136.
[4] CMS First IFR, page 125.
[5] CMS Second IFR (Apr. 30, 2020), page 139 (which includes specific RVUs).

payment for CPT codes 98966-98968, which are intended for practitioners that cannot separately bill for E/M.

The national average valuation of these codes is:

- 99441 = $46.19
- 99442 = $76.15
- 99443 = $110.43
- 98966 = $14.43
- 98967 = $28.15
- 98968 = $41.14

Virtual Care Codes (G2012; G2010)

These services are different than Medicare "telehealth" services in that they are not the kind of services that are ordinarily furnished in person; instead, they are routinely furnished using a telecommunications system. Starting in 2019, CMS began reimbursing for a number of services that could be furnished via telecommunications technology, but are technically not considered Medicare telehealth services:

- HCPCS code G2012: A "[b]rief 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."

Qualifying Patients:

During the COVID-19 public health emergency, G2012 and G2010 may be furnished to both new and established patients. Ordinarily, these are limited to established patients only.

Qualifying Practitioners:

Physicians, qualified healthcare practitioners, and practitioners "such as licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists" may furnish these services during the public health emergency.[6] Ordinarily, only physicians and qualified healthcare practitioners can bill for these services.

Online or Digital E/M (99421-99423; G2061-2063)

Similar to the virtual visit codes described above (G2012, G2010), CMS reimburses for online digital E/M services for up to 7 days cumulative time during the 7 days under CPT codes 99421-99423 for physicians and qualified healthcare practitioners and HCPCS codes G2061-2063 for non-qualified healthcare practitioners.

[6] CMS First IFR, page 54.

- These are time-based codes that describe 5-10 minutes (99421/G2061); 11-20 minutes of medical discussion (99422/G2062); 21-30 minutes of medical discussion (99423/G2063).

Qualifying Patients:

During the COVID-19 public health emergency only, these e-visit codes may be furnished to both new and established patients.

FAQs

Q1: What place of service (POS) code should I use when billing for remote services like digital E/M (99421-99423; G2061-2063)?

A1: For digital E/M (99421-99423; G2061-2063), virtual visits and check-ins (G2012, G2010), and audio-only E/M codes (99441-99443; 98966-98968), do not use POS-02 (telehealth), as these are not Medicare telehealth services. Use the POS code that reflects the applicable site of the practitioner's normal office location.