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Time for a Checkup: Recent Federal Efforts Regarding Telehealth - Part I

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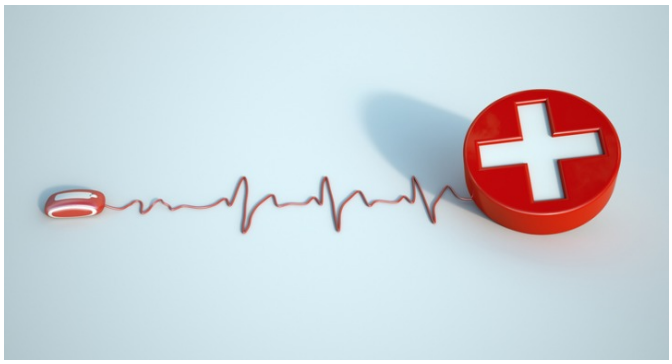
October 28, 2020



The public health emergency (PHE) for COVID-19 has brought about many changes to the way healthcare is practiced, delivered, and reimbursed. This article will discuss some of the major recent changes to telehealth on the federal level.

Disclaimer: For consistency, the term "telehealth" is used throughout this article and is intended to include telemedicine, telepsychiatry, and telenursing.

In a survey conducted by data and analytics company GlobalData between May 27, 2020, and July 2, 2020, on 70 specialists across cardiology, gastroenterology, pulmonology, and respiratory fields, less than half of surveyed specialists indicated that they were using telehealth to treat their patients prior to the pandemic, while 79% indicated that their use of telehealth technology had increased as a result of the pandemic. Of the respondents who reported an increase in use, almost 30% reported an increase of between 81–100%, while 13% indicated an increase of 61–80%.

Much of the increase in use of telehealth was due to necessity. But changes to reimbursement regulations also rapidly expanded access to telehealth services during the pandemic. Some of these changes are discussed below.

In a national study of 1,945 consumers conducted by The Harris Poll and commissioned by Change Healthcare, 89% say COVID-19 made telehealth “an indispensable part of the healthcare system," 65% plan to use telehealth more after the pandemic, and 78% say COVID-19 showed the extent to which more telehealth options are needed.

The current administration also is bullish on telehealth. In a July 15, 2020article Seema Verma, Administrator for the Centers for Medicare and Medicaid Services (CMS), wrote: "In light of our new experience with telehealth during this pandemic, CMS is reviewing the temporary changes we made and assessing which of

these flexibilities should be made permanent through regulatory action." Therefore, all signs point toward telehealth continuing to play a larger role in healthcare as we eventually move beyond COVID-19.

Virtual Services – Pre-PHE

Telehealth – Original Medicare
Original Medicare traditionally has limited payment for telehealth services to specified services meeting the following three requirements:

- The Medicare beneficiary and provider must use a real-time, interactive audio and video telecommunications system;
- The beneficiary must reside in a rural area; and
- The beneficiary must go to a clinic, hospital, or certain another type of medical facility for the telehealth service (i.e., the beneficiary may not be in the beneficiary's home when receiving the telehealth service).

Virtual Check-Ins
Beginning in 2019, Original Medicare has been paying for virtual check-ins (HCPCS code G2012). Because CMS views a virtual check-in as a service that is not provided face-to-face, CMS does not consider such service to be a telehealth service. Such service, therefore, is not subject to the above-mentioned payment limitations on telehealth. That is, audio-only interactions are permitted. The beneficiary need not reside in a rural area. The beneficiary may be in the beneficiary's home when participating in the check-in. However, there are limitations to virtual check-ins:

- The virtual check-in may be provided with an established patient only (i.e., one who has received professional services from the physician or qualified health care professional or another physician or qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years).
- Five to 10 minutes of medical discussion must be documented.
- The practitioner must document in the medical record that the beneficiary does not need to come in for a follow-up visit unless there is a problem.
- The beneficiary must verbally consent to the virtual check-in. The consent must be documented in the medical record. Beginning on January 1, 2020, the practitioner may obtain a single consent for a year’s worth of these services.
- The virtual check-in must not originate from a related evaluation and management (E/M) service provided within the previous seven days. If it does, the service is bundled with the E/M service.
- The virtual check-in must not lead to an E/M service or procedure within the next 24 hours or soonest available appointment. If it does, the service is bundled with the E/M service.
- Telephone calls that involve only clinical staff cannot be billed using HCPCS code G2012 since the code explicitly describes (and requires) direct interaction between the beneficiary and the billing practitioner.
- As a Medicare Part B service, the beneficiary is responsible for a co-payment for the service, and the Part B deductible applies.
- CMS set the reimbursement for this service at approximately $15, citing “low work time and intensity.” For now, there are no frequency limits on this service, although CMS noted it might impose such limits if it detects overutilization.

E-Visits

Beginning in 2020, Original Medicare has been paying for E-visits, which are non-face-to-face, patient-initiated communications through an online patient portal. These types of services do not require the beneficiary to go to the practitioner's office and are available in all types of locations, including the beneficiary's home, and in all areas of the country (not just rural areas). The beneficiary needs to have an established or existing relationship with the practitioner to receive these virtual services.

Telehealth – Medicare Advantage Plans
Traditionally, Medicare Advantage (MA) plans have been limited to providing, as part of their Medicare benefit packages, solely those telehealth services covered under Original Medicare. MA plans seeking to offer a broader scope of telehealth services only could do so as MA supplemental benefits, which were funded through the use of rebate dollars or supplemental premiums paid by enrollees. On April 16, 2019, CMS published a final rule that allows MA plans, beginning in 2020, to include telehealth services in their basic benefit packages (instead of requiring such services to be treated as supplemental benefits) and that allows the beneficiary to receive the telehealth services at the beneficiary's home. Original Medicare's limitation to rural areas and prohibition against in-home services do not apply.

Telehealth – During the PHE

During the PHE, CMS has enacted many changes to broaden access to telehealth services for Original Medicare beneficiaries. An excellent repository of the up-to-date changes are the Frequently Asked Questions (FAQ) guide released by CMS on August 26, 2020. This guide supplements CMS's March 15, 2019 guide. The new guide includes details from COVID-19 legislation, emergency rules, and waivers. The policies included in the new guide are effective for the duration of the PHE unless superseded by future legislation. Some of the major highlights are as follows:

No Payment Restrictions Based Upon Location of Beneficiary
During the PHE, CMS eliminates the requirement that the beneficiary resides in a rural area, eliminates the requirement that the originating site (i.e., the site where the beneficiary receives the telehealth services) be a specified type of healthcare facility, and allows Original Medicare to pay for telehealth services furnished to a beneficiary in the beneficiary's home or any setting of care.

Services Permitted to be Provided via Telehealth
CMS maintains a list of services that may be furnished via Original Medicare telehealth. These services are described by HCPCS code and are paid under the Medicare Physician Fee Schedule when furnished via telehealth.

Equipment Needed to Furnish Telehealth Services
During the PHE, telephone E/M codes and certain counseling behavioral health care and educational services may be furnished as telehealth services using audio-only communications technology (telephones or other audio-only devices). The above-referenced list specifies which services may be furnished using audio-only communications technology. For all other services, an Original Medicare telehealth service requires, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner.

The United States Department of Health and Human Services' Office for Civil Rights has issued a Notification of Enforcement Discretion and related guidance to ensure that covered health care providers may use popular non-public facing applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk of penalty for non-compliance with the HIPAA Rules related to the good faith provision of telehealth during

the PHE.

As we move toward a post-COVID-19 environment, health care providers and organizations should stay aware of the constant changes to regulations governing telehealth services. Our health care attorneys are here to offer sound insight, guidance, and legal services.

[*Ed Note: This is Part I of a two-part series. Click here to read Part II.*]

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