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COVID-19 and the Telehealth Landscape

Executive Summary

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COVID-19 and the Telehealth Landscape

Situation:

The global pandemic brought on by COVID-19 has plunged the healthcare industry into a maelstrom as public interest for safety comes to head with the need for healthcare services. Private clinics, health systems, and outpatient-based provider networks are responding with dizzying speed to changing regulations and a need to restructure care delivery models – not least to be able to temper the effects of COVID-19 on the revenue cycle, but, more importantly, to provide necessary services to members.

Enter telehealth.

Background:

Telehealth was borne from a need to provide coverage to members in rural communities. In today's environment where we are all isolated in our homes – inability to access outpatient care in the traditional sense renders varying degrees of rurality on us all. As such, the Federal and consequent State response to COVID-19 includes a focused mitigation of regulations on telehealth services to establish a safe means for healthcare professionals to provide care to patients without compromising the patient or the public in the face of a global pandemic.

In this report, we will establish a high-level timeline leading to the National Emergency Declaration and provide a framework of the current regulations that prescribe the implementation of telehealth services.

Assessment:

Timeline

On January 31, 2020, the Secretary of Health and Human Services (HHS), Alex M. Azar II, declared the 2019 Novel Coronavirus a Public Health Emergency (PHE) under section 319 of the Public Health Service Act. Although a Presidential declaration of emergency pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act was yet to be signed, Secretary Azar's declaration of a PHE set the stage for a series of regulatory authorizations and rollbacks meant to facilitate a fast and comprehensive response to the impending pandemic facing the Nation and healthcare industry.

On March 6, 2020, President Trump signed into law the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 that allocated $500 million to the Centers for Medicare and Medicaid Services (CMS) to "waive certain Medicare telehealth restrictions during the coronavirus public health emergency" and expand telehealth coverage to beneficiaries regardless of rurality of location.

Within a week, a plethora of regulatory changes were promulgated once President Trump signed a National Emergency Declaration on March 13, 2020 that, amongst other things, allowed States,

regulatory bodies, and CMS to eliminate barriers to patient care, and enable member access and coverage during the PHE.

Recent Regulatory Changes

Broadly, telehealth refers to the distribution of healthcare services and information using electronic and telecommunication technologies to bridge providers with one another for purposes of collaboration, education and training, and with patients for purposes of patient care. Telehealth and telemedicine are often used interchangeably; but the latter is the clinical application of electronic and telecommunication technologies between an appropriately qualified healthcare professional and a patient.

With the intent of supporting infection control and reducing impact on acute care and long-term care facilities inundated with COVID-19 patients, CMS has extended the Medicare Telehealth Services program on a temporary and emergency basis retroactive to March 1, 2020.

Practical implications of these recent regulatory changes mean that patients that would normally be seen in office settings can, through the implementation of technology with audio and video capability, receive care from their healthcare professionals while complying with stay-in-place recommendations.

Healthcare professionals in turn can be reimbursed for these services in parity with regular, in-person visits by following prescribed billing procedures. To ensure accurate billing procedures, CMS is requiring all claims reflect the appropriate place of service for the location where the service would have been rendered had it been conducted in person with modifier code 95.

To support the immediate implementation of telehealth services using commonly available technologies, including FaceTime and Skype, the HHS Office for Civil Rights will waive penalties for HIPAA violations against healthcare professionals that serve patients in good faith. Additionally, the DEA has made exceptions to standard protocols that mandate an in-person evaluation as precedent for prescription. For the period of the PHE, the DEA has authorized the prescription of schedule II-V controlled substances following a real-time, telehealth visit.

Medicare Telehealth Visits

CMS expanded telehealth coverage to pay for office, hospital, and other visits furnished to beneficiaries, both established and new patients, in places of residence, such as home, nursing or assisted living facility. CMS prescribes a specific set of services that are included in the scope of telehealth visits during the PHE that include, but are not limited to, real-time evaluation and

management visits, common office visits, mental health counseling, and preventive health screenings. These regulations also extend to care provided to patients in inpatient rehabilitation facilities, hospices, and home health.

Individual services must verbally be agreed to by the patient at least annually; as such, practitioners must educate beneficiaries on the availability of the service.

Additionally, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

These visits are considered the same as in-person visits and are paid at the same rate as in-person visits.

Billing codes:

Established patients: 99212, 99213, 99214, 99215

New/consult: 99201, 99202, 99203, 99204

Virtual Check-ins

Virtual check-in services are brief interactions with healthcare professionals that CMS has expanded to include both established and new patients regardless of patient's location. Unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication, modalities for virtual check-ins include more options including exchange of information through videos and images, telephone, audio and video, secure text, email, or use of a patient portal.

Individual services must verbally be agreed to by the patient at least annually; as such, practitioners must educate beneficiaries on the availability of the service. Standard co-insurance and deductible will apply.

Billing Codes:

G2010, G2012

E-Visits

E-visits are remote patient communications initiated by the patient through an online patient portal that CMS has expanded to include both established and new patients regardless of patient's location.

Individual services must verbally be agreed to by the patient at least annually; as such, practitioners must educate beneficiaries on the availability of the service. Standard co-insurance and deductible will apply.

Billing Codes:

Practitioners who may independently bill Medicare for evaluation and management visits:

99421, 99422, 99423

Practitioners who may not independently bill for evaluation and management visits:

G2061, G2062, G2063

Telephone Services

Telephone services are evaluation and management services provided by qualified healthcare professionals online or through the phone. CMS has expanded to include both established and new patients regardless of patient's location.

Individual services must verbally be agreed to by the patient at least annually; as such, practitioners must educate beneficiaries on the availability of the service. Standard co-insurance and deductible will apply.

Billing Codes:

99441, 99442, 99443

98966, 98967, 98968

Recommendation:

The motivation behind a swift transition to virtual services considers the interests of everyone involved in care delivery: patient, healthcare professional, frontline hospitals, and the public. Telehealth facilitates a safe environment in which healthcare professionals can appropriately triage and treat patients for existing conditions, provide post-acute care and management, assess potential COVID-19 symptoms, and ensure appropriate continuity of care while mitigating risks of exposure and shifting the demand from emergency departments.

It is critical that patients are informed of their options for telehealth services via telephone calls, member portals, website, social media, grant their consent for telehealth services, and are made aware of potential risks to confidentiality given the technology tools being used.

Standard protocol for the evaluation and transition to telehealth services must take into consideration different modalities available to patients such as phone or video capabilities, access to and varying internet bandwidth, and appropriateness of telehealth service.

As frenzied as most are to transition to telehealth, compliance must be at the forefront of any healthcare entity's planning and preparation. An evaluation of the patient demographic will afford baseline insight in the distribution of Medicare beneficiaries, Medicaid beneficiaries, and commercial members. This insight will then drive billing procedures and mitigate additional risk on the revenue cycle. Although many state licensing boards and commercial insurers are accommodating similar regulatory expansion, it is important to evaluate the compliance and regulatory infrastructure that prescribes telehealth practice for each entity's contracted payers.