SPEAKERS

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Powers’ attorneys represent hospitals and hospital systems, physicians and other healthcare professionals, trade associations, long-term care facilities, home health agencies, pharmacies, managed care organizations and related entities.

This presentation is not to be construed as or relied upon as legal advice.
AGENDA

- Welcome and Introductions
  Philip Schneider, MD
  NASS Advocacy Council
- Legislative Overview, Funding & Relief
  Peggy Tighe
- Telehealth Reimbursement and Billing
  Megan La Suer & Becky Burke
- State Licensure
  Peggy Tighe
- Federal Waivers Related to Telehealth
  Megan La Suer
- Questions
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<thead>
<tr>
<th>Phase</th>
<th>Date</th>
<th>Description</th>
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<td>Phase 1</td>
<td>March 6, 2020</td>
<td>The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020</td>
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<td>$8.3 BILLION emergency funding</td>
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<td>Significant funding to HHS to treat and stop the spread of COVID19</td>
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<td>Phase 2</td>
<td>March 18, 2020</td>
<td>Families First Coronavirus Response Act</td>
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<td>$1 TRILLION</td>
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<td>Targeted relief, individuals &amp; businesses.</td>
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<td>Phase 3</td>
<td>March 27, 2020</td>
<td>The Coronavirus Aid, Relief, and Economic Security (CARES) Act</td>
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<td>$2 TRILLION</td>
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<td>Additional funding to workers, small businesses, impacted industries.</td>
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<td>Phase 3.5</td>
<td>April 24, 2020</td>
<td>Paycheck Protection Program and Health Care Enhancement Act</td>
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<td>$484 BILLION total</td>
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<td>$310 BILLION, Paycheck Protection Program</td>
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<td>$75m to hospitals, $25m to support testing.</td>
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OVERVIEW OF FUNDING & RELIEF

- DIRECT ALLOCATIONS TO PROVIDERS
- SMALL BUSINESS RELIEF
- FCC TELEHEALTH FUNDING
- REGULATORY RELIEF
  - INSURANCE
  - TELEHEALTH
  - LICENSURE
KEY FUNDING: CARES

- **CARES ACT:** $2 TRILLION financial relief to small businesses, to support health care workers, to get medical supplies to the front lines, to fund research for treatments and vaccines, and to stimulate the U.S. economy.

- **PROVIDER RELIEF FUND:** $100 BILLION
  - **FIRST ALLOCATION** - $30 BILLION, based on Medicare FFS 2019 reimbursements, began April 10
  - **SECOND ALLOCATION** - $20 BILLION, began April 24
  - Some of remaining $50 BILLION, set aside for uninsured (Secretary Azar)
KEY FUNDING: LOANS & MORE PROVIDER AID

- PAYCHECK PROTECTION/ ADDITIONAL HEALTH CARE ENHANCEMENTS – Additional $75 billion
  - Paycheck Protection Funds depleted, recently replenished by bill
  - $10 BILLION targeted relief for HIGH IMPACT areas
  - Timing and manner of distribution uncertain

- SMALL BUSINESS ADMINISTRATION RELIEF
  - Economic Injury Disaster Loan (EIDL) Emergency Advance
  - SBA Express Bridge Loans
  - SBA Debt Relief

LINK: SBA Loan and Debt Relief Options
$200 million for Federal Communications Commission (FCC) grants to help practitioners provide connected care services to patients remotely during the pandemic.

- So far, the FCC has awarded $6.94 million to 11 health systems in 8 states.

See link to FCC Telehealth Funding
On April 27, CMS announced that it is reevaluating the amounts that will be paid under its Accelerated Payment Program and suspending its Advance Payment Program to Part B suppliers effective immediately.

CMS stated, “Significant additional funding will continue to be available to hospitals and other healthcare providers through other programs.”

CMS said that CARES funding through the Provider Relief Fund will not have to be repaid.
REGULATORY RELIEF

- NASS – Members of Regulatory Relief Coalition [See Link to RRC Website]
  - Request to CMS to Relieve Burden of Prior Authorization [See RRC Letter]
    - April 23, CMS strongly encouraged plans to waive PA requirements. [See CMS Link]
    - Letters sent to all Governors and Insurance Commissioners
- State Actions [See NAIC State Tracking]
- Telehealth – Burke & La Suer
- Licensure - Tighe
MA and Medicare Part D Plans – CMS updated 3-10-20 guidance to MA and Part D plans, Specific guidance includes the following:

- **MA Plan Benefits** – MA plans can add or expand benefits that address issues or medical needs raised by COVID-19, including meal delivery or medical transportation services;

- **MA Plan Prior Authorization** – CMS encouraged plans to consider waiving or relaxing “prior authorization requirements” to facilitate access and create less burden for beneficiaries, plans, and providers.”

- **Part D Plan Prior Authorization** – CMS encouraged Part D plans to consider waiving or relaxing prior authorization “requirements at any time for other formulary drugs…to facilitate access and create less burden for beneficiaries, plans, and providers.”

- **CARES Act Part D Requirements** – CMS outlined CARES Act requirements, including that Part D plans regarding 90-day supply limits for covered drug coverage.
The CARES Act, signed into law on March 6, 2020, provides $8.3 billion in emergency funding for federal agencies to respond to the coronavirus outbreak.

Key Component

Granted the Secretary of HHS broad discretion, under Section 1135 of the Social Security Act, to waive Medicare statutory rural and site of service coverage restrictions on services provided via telehealth.
SECTION 1135(B)(8) WAIVER

- Retroactive to March 6, 2020
- Waives Medicare coverage for telehealth services regardless of whether patient is in a rural area
- Waives the “originating site” requirement, meaning services can be provided to beneficiaries in any healthcare facility, as well as in their home.
- Is not limited to telehealth services related to COVID-19 and applies to any medically necessary covered service.
Medicare Advantage Plans are required to cover the same services as regular Medicare Parts A and B (42 CFR Section 422.201)

Because Medicare Part B is now covering telehealth in non-rural areas and when patient is in the home, this should mean that Medicare Advantage plans must provide the same coverage.

Previously, MA plans had the option of providing expanded telehealth benefits as part of their basic benefits.
**DISTANT SITE**

- Where the physician or practitioner is located at the time the service is provided, via a telecommunications system.
- FQHCs and RHCs added as distant side providers
- Eligible distant site providers
  - Physicians
  - Nurse practitioners (NPs)
  - Physician assistants (PAs)
  - Nurse-midwives
- Clinical nurse specialists (CNSs)
- Certified registered nurse anesthetists
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Registered dietitians or nutrition professionals
- FQHCs and RHCs
- Does not include physical or occupational therapist.
Will clinicians be paid the same amount by Medicare for telehealth services as they would for in-person services?

- Yes. During the COVID-19 PHE, Medicare will reimburse the same rate as the physician/QHP would receive had the patient been seen in person. Office-based physicians/QHPs (POS 11) will be reimbursed the higher non-facility rate. This rate will apply even if the physician provides the telehealth service from his/her home. If the physician normally sees patients in a hospital outpatient department or provider-based clinic, then they would be paid the facility rate for telehealth services, just as they normally would.
What if the physician provides telehealth services from their home?

- In order to prevent the spread of COVID-19, many physicians/QHPs are choosing to provide telehealth services from their home. CMS has stated that there will be no payment restrictions on distant site practitioners who provide telehealth services from their home during the PHE.

- Medicare will pay the same amount for telehealth services as if the services were provided in person. Providers should use the CPT code that properly describes the service and include both the 95 modifier and the POS code that would have been used had the service been provided in person.
Can physical therapists, occupational therapists, and speech language pathologists bill as distant site providers?

- No. They do not meet the definition of “distant site” providers in the Medicare statute. However, CMS has stated that it is considering whether it has authority to waive this requirement.

Can urban providers such as hospitals bill an originating site fee?

- No. Providers providing telehealth services under the 1135 waiver cannot bill an originating site fee.
NEW TELEHEALTH SERVICES

- CMS announced, in the IFR, broad expansion of services that can be provided via telehealth.
- Covered services now include, among others:
  - Emergency department visits
  - Observation day management
  - Critical care
  - Home visits
  - Intensive care
  - Radiation treatment management
**TELEHEALTH BILLING REQUIREMENTS**

- “Originating site” facility fee claims must include HCPCS code “Q3014.”
  - Current originating site fee for CY 2020: $26.65
- “Distant Site” (i.e. where clinician is located) bills same CPT/HCPCS code they would bill if service provided in person (e.g., E/M codes)
  - Use modifier 95 and Place of Service (POS) code that would be used if service provided in person. (Note, under IFR, practitioners should not use POS 2)
- Medicare pays the same amount for telehealth services as it would if the service were furnished in person.
  - Use the designated CPT code that describes the service.
  - Medicare will now pay at higher non-facility rate for services provided in physician office (POS11)
NEW AND ESTABLISHED PATIENTS

- Established Patient Requirement Eliminated for:
  - Medicare telehealth services (e.g., E/M visits conducted via audio-visual real time communication) can now be provided to new and established patients.
  - Remote patient monitoring
  - Telephone calls and virtual check-ins
  - Digital e-visits
What place of service (POS) and modifiers should be used on the Medicare claim to signify that a provider is furnishing health care services via telehealth instead of in person?

- Physicians and qualified health practitioners (QHPs) furnishing outpatient telehealth services during the PHE should use the POS code that they would have otherwise used had the service been provided in person. Medicare is no longer requiring use of the POS 2 code. CMS requires providers to also include the 95 modifier to identify services as a Medicare telehealth service.

- Additionally, providers should continue to use any special modifiers that applied prior to the COVID-19 PHE (i.e. “GQ”, “GT”, or “G0”).
Can we get paid for a telehealth visit if the patient and the physician/QHP are in the same location (e.g., in the hospital or provider-based clinic) but the service is furnished via telecommunications technology due to exposure risks?

In this case, because the physician and patient are in the same location, CMS has instructed that the visit be treated as an in-person rather than a telehealth visit. Thus, while the physician/QHP would get reimbursed for the service, the service does not need to be identified as a telehealth service.
Can a physician or QHP provide direct supervision through remote audio/visual technology rather than being on-site?

Yes. During the COVID-19 PHE, physicians/QHPs can satisfy the “direct supervision” requirements outlined in the Medicare “incident to” rules using real-time interactive audio and video technology where the physician or QHP deems it necessary for the purpose of reducing exposure risks for the beneficiary and health care provider.
Do I need to change my enrollment status now that I am providing health care services to Medicare beneficiaries from home?

No. Medicare physicians/QHPs do not need to update their enrollment status to notify CMS that they are providing telehealth services to Medicare beneficiaries from their homes.

How should the evaluation and management (E/M) code level be selected when the service is provided via telehealth?

During the PHE, CMS will allow outpatient visit codes to be based on medical decision making or time even if counseling and coordination of care are not 50% of the visit. When coding based on time, use the typical visit times for the E/M codes on the CMS website, available at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F
Are there limits on how often Medicare telehealth services can be provided in certain institutional settings?

Yes; however, CMS has relaxed many of these limits during the PHE. Before the COVID-19 PHE, hospitals could only provide and bill for telehealth subsequent inpatient services once every three days, critical care consultation could only be billed once per day, and skilled nursing facilities (SNF) could only bill once every 30 days. During the PHE, CMS lifted these frequency limitations for subsequent inpatient, critical care, and SNF visits furnished via telehealth. CMS also relaxed the monthly, face-to-face visit for certain home dialysis treatment.
REVISED “INCIDENT TO” SUPERVISION RULES

- Medicare requires that clinical staff work on “direct supervision” of the practitioner for most services. However, under new rules, “direct supervision” can be performed through audio/video real-time communications technology.

- Must be for purpose of reducing exposure risks for the beneficiary or health care provider.
  - Individual practitioners are in the best position to make decisions based on their clinical judgement if their physical presence is necessary.
TELEPHONE CALLS

- Medicare will now pay for audio-only phone calls
  - Virtual Check-ins; brief 5-10 minute call (HCPCS Code G2012)
  - CPT Codes for telephone calls: 98966-98968 for clinical staff or other professionals (e.g., LCSWs, PTs, OTs, clinical psychologists)
- Not limited by patient location
- CPT Codes 99441-99443 for clinicians
- Cannot be within 7 days of E/M for same problem
- Cannot lead to E/M or procedure within 24 hours (or first available appt.)
DIGITAL E-VISITS

- Patient-initiated communication between patient and practitioner using online patient portals.
  - No geographic or location restrictions
  - Can only be billed once per 7 days
  - Can range from 5 to 21 or more minutes
- New or established patients
- CPT Codes 99421-99423 (clinicians)
- HCPCS codes G2061-G2063 for Medicare or CPT Codes 98970-98972 (clinical staff; other professionals)
  - CMS Examples: physical therapists, occupational therapists, speech language pathologists, and clinical psychologists can bill G2061-G2063 to Medicare
REMOTE PATIENT MONITORING (RPM)

- Used as follows:
  - Must be for remote monitoring of physiologic parameters
  - Patient can be in their home
  - Monitoring can last several weeks or months
  - Must be for treatment management
  - Can now be for new and established patients
  - Acute or chronic conditions
- Use Codes 99453-99458
- Patient consent required but can be obtained annually – document in medical record
MEDICAID AND TELEHEALTH EXPANSION

- States already have considerable flexibility to cover telehealth under their state plans.
- No federal approval is needed to reimburse telehealth visits in the same manner as face-to-face services.
- Other changes may require waivers but CMS will streamline approval processes.
- Almost all states have been granted section 1135 waivers to date.
- CMS COVID-19 Medicaid Waiver Checklists
MEDICAID AND TELEHEALTH EXPANSION

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- CMS COVID-19 Medicaid Waiver Checklists.
RESOURCES

- POWERS LAW COVID RESOURCES
- CMS MEDICARE FAQS
- MEDICARE TELEMEDICINE TOOLKIT
- MEDICARE TELEMEDICINE FACT SHEET
Section 1135 of the Social Security Act dissected and explained…

- the Secretary may temporarily waive or modify…
- certain Medicare, Medicaid, and Children’s Health Insurance Program (CHIP) requirements…
- to ensure that sufficient health care items and services are available…
- to meet the needs of individuals enrolled in Social Security Act programs…
- in the emergency area and time periods and that providers who provide such services in good faith…
- can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse).
1135 Waivers Examples

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Requirements that physicians and other health care professionals hold licenses in the State in which they provide services if they have a license from another State and are not affirmatively barred from practice in that State or any State in the emergency area (note however, that this waiver is for the purposes of Medicare, Medicaid, and SCHIP reimbursement only – states determine whether a non-Federal provider is authorized to provide services in the state without state licensure).
- Emergency Medical Treatment and Labor Act (EMTALA)
- Stark self-referral sanctions
- Performance deadlines and timetables may be adjusted (but not waived).
- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

TELEHEALTH, STATE LICENSURE (CONT’D)

IMPORTANT CAVEATS

States are expanding Medicaid telehealth services with and without federal waivers. Center for Connected Health Policy is tracking this around the country. Check for action by YOUR STATE.

CHECK STATE LAWS/RULES
Some states have more flexible telehealth and licensure provisions.

- Reimbursement by commercial payors (non-Federal payors) is governed by STATE LAW.
- Licensure is also regulated by states (10th amendment to U.S. Constitution) and is most often tied to where the patient is located.
EFFORTS TO EXPAND

• Secretary Azar sent a letter to Governors on March 24 asking for more across-state-lines licensure relief. Most states are engaged, continually changing.
• National Governor’s Association calling for states to provide more flexibility:
  NGA Released Recommendations to States
  1. Expanding access to out-of-state licensed health care providers and telehealth.
  2. Maintaining and increasing the number of providers by easing in-state licensure requirements.
  3. Expanding medical facility and testing capacity by temporarily loosening licensure and reimbursement requirements for facilities
TELEHEALTH, STATE LICENSURE (CONT’D)

RESOURCES

- 1135 Waivers At A Glance (PDF)
- Requesting an 1135 Waiver 101 (PDF) *
- CMS Presentation on 1135 Waivers (PDF)
- 1135 Waivers Authority (PDF)
- Information to Provide for an 1135 Waiver Request (PDF)
- PHE Questions and Answers (PDF)
FEDERAL WAIVERS RELATED TO TELEHEALTH
MEGAN LA SUER
Relaxation of HIPAA Requirements for Telehealth

- HHS will not impose HIPAA penalties if “good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency.” Telehealth service does not have to be related to COVID-19.
- The Waiver Notice outlines acceptable and unacceptable applications, as well a list of vendors that provide HIPAA compliant communication products.

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<th>Acceptable Applications</th>
<th>Unacceptable Applications</th>
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<tr>
<td>• Apple FaceTime</td>
<td>• Facebook Live</td>
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<tr>
<td>• Facebook Messenger video chat</td>
<td>• Twitch</td>
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<tr>
<td>• Google Hangouts video</td>
<td>• TikTok</td>
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<td>• Skype</td>
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TELEHEALTH AND SANCTIONS FOR WAIVER OF BENEFICIARY PAYMENTS

- HHS-OIG will *not* impose sanctions on practitioners for waiving copayments on telehealth services or providing free telehealth services.
  - Telehealth service does not have to be related to COVID-19.
  - No requirement that providers waive Medicare co-payments

- Conditions
  1. The cost-sharing obligation must be related to telehealth services furnished consistent with the then-applicable coverage and payments rules; and
  2. The telehealth services are furnished during the time period subject to the COVID-19 public health emergency declaration.
Controlled substances may be prescribed as the result of a telehealth visit for a new patient if:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
- The practitioner is acting in accordance with applicable Federal and State law

Controlled substances may be prescribed for established patients through telephone
STARK WAIVER

- CMS waiver of certain Stark prohibitions
  - Must relate to a direct financial relationship between a physician and provider
  - Must be in response to COVID-19
    - CMS example of permissible action under waiver:
      - An entity provides free telehealth equipment to a physician practice to facilitate telehealth visits for patient

- CMS Waiver:
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