2022 MHA HEALTH SUMMIT

Telehealth and Virtual Services

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Telehealth vs. Virtual Services (Medicare)

Telehealth

- Takes the place of what would otherwise be a face-to-face encounter

Virtual Services

- No equivalent face-to-face service; use of technology key component of service
- Care management; remote monitoring; virtual (telephonic) check-ins and e-visits (no related E/M service)

Medicare Telehealth Coverage Pre-COVID-19

Section 1834(m)

1. **Geographic** - Patient must reside in rural area
2. **Location** - Patient must be physically present at healthcare facility when service is provided (facility fee)
3. **Service –** Coverage limited to CMS' list of approved telehealth services (CPT and HCPCS codes)
4. **Provider –** Service must be provided by physician, non-physician practitioner, clinical psychologist, clinical social worker, registered dietician, or nutrition professional
5. **Technology** - Must utilize telecommunications technology with audio ***and*** video capabilities that permits real-time interactive communication**.**

Medicare Coverage Pre-COVID-19

With Some Exceptions

- **Telestroke**
  - Effective 01/01/2019, geographic and location requirements do not apply to services furnished to diagnose, evaluate, or treat symptoms of acute stroke
- **Substance Use Disorder**
  - Effective 07/01/2019, geographic and location requirements do not apply to services relating to SUD and co-occurring behavioral health conditions
- **ESRD**
  - Effective 01/01/2019, geographic and location requirements do not apply to ESRD services relating to home dialysis
- **Medicare Advantage**
  - Beginning in 2020 plan year, MA plan may eliminate geographic and location requirements
- **Medicare Shared Savings Program**
  - Waiver of geographic and location requirements for ACO participants in risk models
- **CMMI Initiatives**

Medicare Telehealth Coverage Expansion

1. Legislative Action

- Authorized Secretary to waive Section 1834(m) requirements for duration of PHE

2. CMS Interim Final Rules

- Suspends certain *service* restrictions for duration of PHE
  - Expands list of covered services
  - Eliminates frequency requirements
  - Permits use of telehealth for required face-to-face visits, direct supervision for incident-to billing, teaching physician presence
- Suspends certain *provider* restrictions for duration of COVID-19 PHE
  - Waives Medicare state licensure requirement (but not state law requirements)
  - Permits therapists and S/L pathologists to provide covered services via telehealth
  - Permits FQHCs and RHCs to bill for telehealth services under HCPCS G2025
  - Permits billing for hospital outpatient department and critical access hospital (Method 1 billing) services furnished via telehealth
- Authorizes payment for certain audio-only E/M services (CPT 98966-68, 99441-43)
- Provides reimbursement for telehealth services at higher non-facility rates to compensate practices for telehealth-associated costs

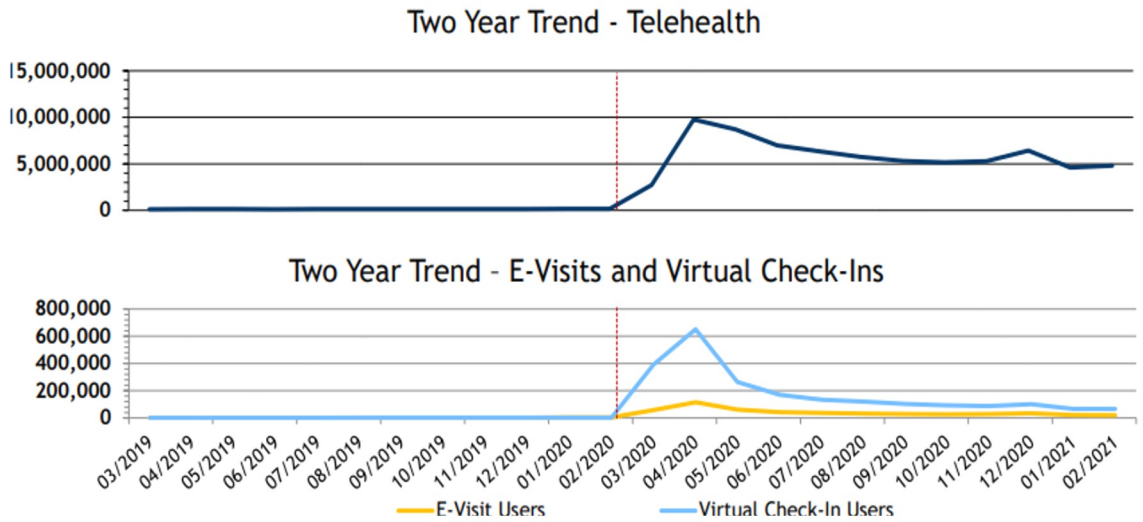
Medicare Telehealth Coverage Expansion

3. Other Agencies' Actions

- Office of Civil Rights Notice of Enforcement Discretion - Will not impose penalties if, in good faith, use any non-public remote audio/visual communication product
- Office of Inspector General Notice of Enforcement Discretion– Permits waiver of co-insurance
- Drug Enforcement Administration – Use of telehealth for in-person medical evaluation prior to prescribing scheduled II – V controlled substances

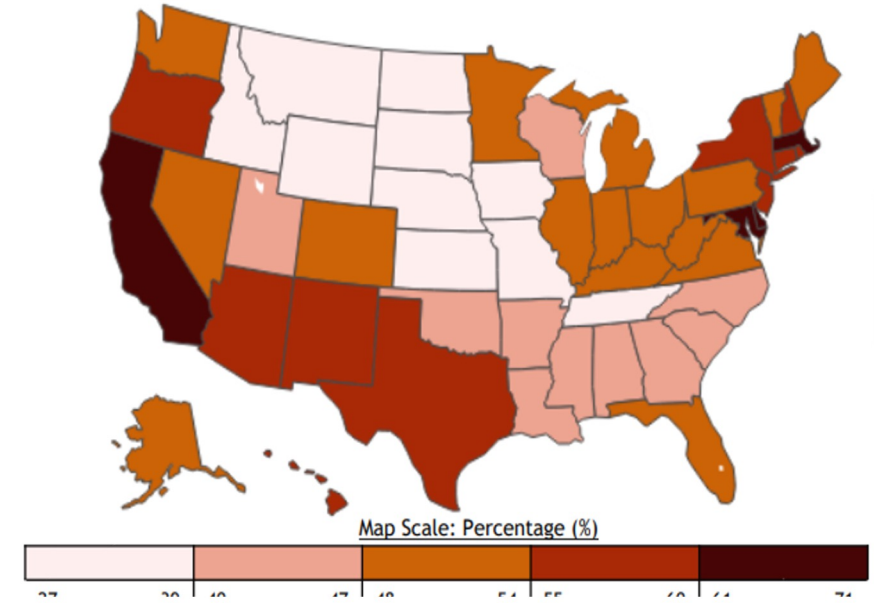
Utilization

Telemedicine Users: Pre-Pandemic and Pandemic Period				
	Total	Telehealth	E-visit[1]	Virtual Check-In
Pre-pandemic (March 1, 2019 - Feb 29, 2020)	**910,490**	892,121	5,220	14,088
Pandemic (March 1, 2020 - Feb 28, 2021)	**28,255,180**	27,691,878	367,467	1,601,033



28,255,180 Unique Telemedicine Users

53% of Medicare Users



Rural Areas: **44%**

Urban Areas: **55%**

www.cms.gov/files/document/medicare-telemedicine-snapshot.pdf

Impact

- Telehealth follow-up was associated with lower 30- day readmissions than no timely post-discharge follow-up, but was associated with slightly higher 30-day readmissions than in-person follow-up.
  - CMS Data Highlight (January 2022) www.cms.gov/files/document/omh-data-highlight-2022-1.pdf
- Data suggests that telehealth expansions improved access to medication treatment and contributed to lower use of inpatient and/or emergency department visits among beneficiaries with OUD.
  - CMS Data Highlight (January 2022) www.cms.gov/files/document/data-highlight-jan-2022.pdf

The End is Near, But How Close Is It?

- Renewed through April 16
- Likely to be extended, but for how long?
  - HHS promises 60 days' advance notice (but probably not more)
- Legislative attempts to end PHE
- State and local PHEs
  - Some federal waivers tied to state pandemic plan
- Over before it's over
  - As of March 22, Uninsured Program no longer accepting new claims for testing or treatment for uninsured patients
  - As of April 5, no longer accepting new claims for COVID-19 vaccinations

Tele-Behavioral Health

- Consolidated Appropriations Act, 2021 – eliminate geographic and location restrictions for diagnosis, evaluation, and treatment of mental health disorder
- Must have in-person, non-telehealth service by practitioner in same practice as billing practitioner within 6 months prior to initial telehealth service + each 12 months thereafter
  - Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with reason documented in beneficiary's medical record)
- May use audio-only communication technology (vs. audio/video required for other telehealth services) but only if -
  - Practitioner has audio/video capability + beneficiary lacks capacity or refuses to use video connection
    - Documented in medical record + include service-level modifier on claim

Telehealth Flexibility Extensions

Enacted March 15, 2022

- For 151 days post-PHE –
  - ✓ Continuation of waiver of geographic and location requirements
  - ✓ Continuation of reimbursement for therapist and S/L pathologist telehealth services
  - ✓ Continuation of reimbursement for audio-only services
  - ✓ Continuation of FQHCs and RHCs for telehealth services
  - ✓ Continuation of use of telehealth to recertify eligibility for hospice case
  - ✓ Delay in in-person requirement for initiation of tele-behavioral health services

Not Extended Post-PHE

- Billing for hospital outpatient department and critical access hospital (Method I billing) services furnished via telehealth*
- Waiver of requirement to be licensed in state in which patient receiving telehealth services is located*
- Use of telehealth to perform –
  - Required in-person visits (ESRD/home dialysis, nursing facility, home health)*
  - In-person medical evaluation for prescription of controlled substances*
  - Direct supervision for incident-to billing for in-person services (now extended thru 12/31/22)
  - For residency training sites within MSA, teaching physician presence for key portions of service
- Reimbursement at non-facility rate (return to use of POS 02; addition of POS 10)
  - Update Medicare enrollment to list practitioner's home?

* ***Most likely requires legislative action***

Not Extended Post-PHE, Con't

- Telehealth frequency limits for subsequent inpatient visits (once/3 days), subsequent SNF visits (once/14 days), critical care consults (once/day)
- OCR/OIG enforcement discretion + DEA controlled substances waiver
- Reimbursement for the following as telehealth services

  - Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) (CPT 99304-99306)
  - Initial hospital care (CPT 99221-99223)
  - Radiation Treatment Management Services (CPT 77427)
  - Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324- 99328)
  - Home Visits, New Patient, all levels (CPT 99341- 99345)
  - Inpatient Neonatal and Pediatric Critical Care, Initial (CPT 99468, 99471, 99475, 99477)
  - Initial Neonatal Intensive Care Services (CPT 99477)
  - Initial Observation and Observation Discharge Day Management (CPT 99218 – 99220; CPT 99234- 99236)
  - Medical Nutrition Therapy (CPT G0271)

  - Reimbursement for Category 3 telehealth services expires 12/31/23 (www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Virtual Services

- Scope
  - Care management (CCM, Complex CCM, PCM)
  - Remote monitoring (RPM and RTM)
  - Virtual (telephonic) check-ins
  - e-visits
- For duration of PHE -
  - May provide services for new and established patients
    - Still must obtain consent at initiation of services
  - May waive co-insurance (CMP enforcement discretion extends to these services)
  - For remote physiologic monitoring, only 2 days of data collection required for COVID-19 patients (vs. 16 days)

Montana Medicaid

- Providers may provide services via telehealth if service -
  - is clinically appropriate for delivery by telehealth as specified by department rule or policy
  - comports with guidelines of applicable Medicaid provider manual
  - is not specifically required in applicable provider manual to be provided face-to-face
- Telehealth services must be reimbursed at same rate of payment as services delivered in person

Commercial Payers - Montana Parity Law

- Effective January 1, 2022
- Private payers regulated under state law required to provide coverage for services delivered through telehealth if service covered when provided in-person by health care provider or facility
  - "use of audio, video, or other telecommunications technology or media, including audio-only communication, that is: (A) used by a health care provider or health care facility to deliver health care services; and (B) delivered over a secure connection that complies with the requirements state and federal privacy laws. The term does not include delivery of health care services by means of facsimile machines or electronic messaging alone."
  - No face-to-face initiating visit required (except to prescribe medical marijuana)
  - No restrictions regarding patient location
  - ***No explicit payment parity***

How Can We HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services