American Society of Anesthesiologists™

Timely Topics
Payment and Practice Management

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Telehealth: Background and Flexibilities Extended During the Public Health Emergency

During the Public Health Emergency (PHE) declared to respond to the COVID-19 virus, many practices are looking to provide care via telehealth. Because this mode of delivery is so very appropriate under our current challenges where we need to ensure care is provided to COVID and non-COVID patients in a way that minimizes risks of exposure to both patients and healthcare professionals, the Centers for Medicare & Medicaid Services (CMS) has been issuing waivers and flexibilities to encourage the use of telehealth.

Some medical practices may have already implemented telehealth, but it may be a new option for others. As such, it may be best to start with a basic Telehealth 101 and then move on to review of what has been changed for the duration of the PHE.

Included in CMS's Medicare Learning Network (MLN) offerings, Telehealth Services (MLN901705 March 2020) provides a thorough yet succinct introduction to the basics of telehealth.

At this point, I suggest you review that document and then return to this article to read about what has changed for the duration of the PHE.

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Interim telehealth changes relevant to ASA members include:

Provision of telehealth services is no longer limited to specified locales; it is available to any patient anywhere in the country.

The patient does not need to be in a designated originating site. Patients may receive telehealth care from their homes.

The distant site (where the physician or qualified healthcare professional is located) can be the professional's home. CMS has clarified that the professional does not need to update his/her Medicare enrollment files to include his/her home address. The home address should be listed on the claim form as the site where the care was rendered.

While some may be interpreting the latest CMS guidance to mean that telehealth may be done via audio only and that video capability is not required, be aware that others with expertise in interpreting CMS communications hold a different view, based on how CMS defines an interactive telecommunications system: *"For the duration of the public health emergency as defined in § 400.200 of this chapter, 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."*[1] We can expect more advocacy efforts specific to this matter.

[1] CMS-1744-IFC Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency

The Health and Human Services Office of Civil Rights (HHS OCR) will waive HIPAA penalties for good faith use of common technologies such as Face Time and Skype.

The list of services that may be provided via telehealth has been expanded. The new list is available at https://www.cms.gov/files/zip/covid-19-telehealth-services-phe.zip

When there is a distinction between a facility payment rate and a non-facility rate, rather than issuing payment at the facility rate as has been the case for telehealth, the payment rate will reflect the rate that would have been paid had the service been provided in person. This is an important distinction as the differential can be significant for some services. To accomplish this, CMS has revised its instructions on how to report services performed via telehealth. They should be reported using the CPT® that describes the service but instead of reporting with Place of Service (POS) Code 02 – Telehealth, CMS now states to report the POS that would have been used if the service was provided in person and to append CPT's telehealth modifier (Modifier 95) to the CPT code.

Restrictions on how frequently a service may be provided via telehealth have been lifted. For example, previous subsequent hospital visits (codes 99231 – 99233) could be provided by telehealth once every three days. That is no longer the case under the interim flexibilities.

In addition to the above changes specific to telehealth, there are interim revisions applicable to other non-face to face services:

E-visits and virtual check-ins may be used for both new and established patients. These codes are not reported in the same way as telehealth services but via specific CPT /HCPCS codes that describe them. For example, see codes 99421 – 99423, and G2010 and G2012.

Non-face-to face telephone services (CPT codes 99441 -99443 and 98966-98968) will be considered covered services by Medicare – a change to their previous coverage status – and applicable to both new and established patients. CMS states this change is necessary, "especially in the case that two-way, audio and video technology required to furnish a Medicare telehealth service might not be available…"

Telehealth may be an option for pain medicine practices to help you continue to care for patients who still need you. Since the new list of services that may be provided via telehealth includes inpatient care such as initial and subsequent inpatient hospital visits (codes 99221-99223 and 99231-99233) and critical care (99291, +99292) , anesthesiologists serving as intensivists may also want to consider this option.

One final note: Information about telehealth has been changing dynamically over recent weeks. Be sure to check the date of any resources you use to be sure that they reflect the most current and up to date information.

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For more information: (current as of 3/31/2020)

https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

https://www.cms.gov/files/document/covid-final-ifc.pdf

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index

https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf (see FAQ #12)