

March 19, 2020

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION  
M E M O R A N D U M**

TO: Chief Financial Officers, Member Hospitals and Health Systems  
Patient Financial Services

ROUTE TO: Revenue Cycle, Managed Care

FROM: Cassie Yarbrough, Director, Medicare Policy  
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SUBJECT: COVID-19 Medicare Telehealth Coverage Expansion Authorities

The President's March 13, 2020 declaration of a national emergency coupled with the Secretary of the Department of Health and Human Services' (HHS) January 31 declaration of a public health emergency has granted the Secretary of HHS new authority under Section 1135 of the Social Security Act to waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements. Over the past week, HHS has announced a series of these "1135 waivers" in response to the COVID-19 public health emergency. **This memorandum focuses specifically on the section 1135 blanket waiver issued on March 17 for Medicare telehealth services and related permissive authorities granted to Medicare Advantage (MA) organizations and Part D sponsors.**

IHA will provide detailed information on HHS' other 1135 blanket waivers, as well as the Pritzker administration's application to expand Medicaid coverage in Illinois, in a forthcoming communication. Please check IHA's COVID-19 [webpage](#) for the latest information.

**Section 1135 Medicare Telehealth Waiver**

On March 17, the Centers for Medicare & Medicaid Services (CMS) implemented an 1135 blanket waiver for Medicare telehealth services. This waiver allows for additional flexibilities in providing and being reimbursed for telehealth services rendered to the traditional Medicare population. Specifically, Medicare will pay for office, hospital, and other visits furnished via telehealth across the entire country, whether urban or rural, and in all settings, including in patients' homes. This waiver is effective starting March 6, 2020, and will remain in place for the duration of the COVID-19 public health emergency.

In a [fact sheet](#) on the telehealth waiver, CMS clarifies that it is not limited to patients with or suspected of having COVID-19. Providers may treat patients through telehealth regardless of their diagnosis or symptoms, so long as services are reasonable and necessary. CMS also reminds providers of the availability of virtual check-ins with established patients to determine whether an office visit is necessary. Further, CMS reaffirms that established Medicare patients may have non-face-to-face patient-initiated communications with their doctors via online patient portals in all locations and all areas of the country.

*Regulatory Enforcement Discretion*

While Medicare coinsurance and deductible liabilities generally still apply to these services, the HHS Office of Inspector General (OIG) is allowing health care providers to reduce or waive cost-sharing for telehealth visits paid for by federal programs. More information on the OIG’s enforcement discretion can be found [here](#). Furthermore, effective immediately, the HHS Office of Civil Rights is waiving penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency. More information on HIPAA enforcement is available [here](#). Additionally, HHS will not conduct audits to ensure that an established relationship between the provider and patient existed prior to provision of telehealth services.

*Qualified Telehealth Providers*

During the public health emergency, Medicare will allow the following providers to furnish telehealth services: physicians; certain non-physician practitioners, such as nurse practitioners, physician assistants, and certified nurse midwives; certified nurse anesthetists; licensed clinical social workers; clinical psychologists; and registered dietitians or nutrition professionals. Qualified providers must act within their scope of practice and in accordance with Medicare benefit rules.

It is important to note that while this waiver provides significant flexibility regarding qualified telehealth providers, CMS does not allow clinicians to legally provide telehealth services in another state if they have an equivalent qualifying license in their home state. IHA, in partnership with the American Hospital Association and other state partners, will continue to work with the federal government to demonstrate the limitations and challenges associated with this issue.

*Covered Services, Billing, and Reimbursement*

Services rendered by qualified providers will be reimbursed at the same rate as regular, in-person visits. In cases where Medicare’s site-of-service reimbursement policies apply (office vs. facility), Medicare will pay the facility rate for telehealth services. On-site visits conducted via video or through a window in a clinic may not be billed as telehealth services.

Reimbursement of telehealth services is generally limited to professional fees, which should be billed on the 837P/CMS-1500 with Place of Service (POS) code 02 (telehealth). Critical Access Hospitals (CAHs) may report telehealth services under CAH Method II with the GT modifier. Facilities may only bill for the originating site facility fee if the beneficiary is in the facility while receiving the telehealth services. Under the waiver, the facility fee is not limited to facilities located in a rural area or health professional shortage area. When appropriate, the facility fee may be billed on the 837I/UB-04 with HCPCS code Q3014.

A summary of Medicare Telehealth Services is in the table below.

Type of Service	Service Description	HCPCS/CPT Code	Patient/Provide Relationship
Medicare Telehealth Visits	A visit with a provider that uses telecommunication systems between a	99201-99215 (Office or other outpatient visits)	For new* or established patients.
		G0425-G0427 (Telehealth consultations, emergency department or initial inpatient)	
		G0406-G0408 (Follow-up inpatient telehealth	

	provider and a patient	consultations, furnished to beneficiaries in hospitals or SNFs)	*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
		For a complete list: <a href="https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes">https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes</a>	
Virtual Check-In	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation or recorded video and/or images submitted by an established patient.	HCPCS code G2012	For established patients
		HCPCS code G2010	
E-Visits	A communication between a patient and their provider through an online patient portal.	99431	For established patients.
		99422	
		99423	
		G2061	
		G2062	
		G2063	

Additional information on covered services, billing, and reimbursement may be found in CMS' [Medicare Telehealth FAQ](#) (March 17, 2020).

**Medicare Part C, Part D, and Medicare-Medicaid Plans**

In a March 10, 2020 [Memorandum](#), CMS informed Medicare Advantage (MA) plans that they must comply with special requirements in the event of a declaration of emergency or disaster by a state Governor. Given Governor Pritzker's March 9 [Disaster Proclamation](#), MA plans must implement the following special requirements for at least 30 days:

1. Cover Medicare Parts A and B services and supplemental Part C plan benefits furnished at non-contracted facilities, as long as the non-contracted facilities participate in original Medicare.
2. Waive, in full, requirements for gatekeeper referrals where applicable.
3. Provide the same cost-sharing for the enrollee as if the service or benefit had been furnished at a plan-contracted facility.

4. Make changes that benefit the enrollee effective immediately without the 30-day notification requirement, such as reductions in cost-sharing or waiving prior authorization requirements.

Although these special requirements do not provide for expanded telehealth coverage, CMS has granted MA plans “permissive” authority to take actions similar to those allowed under the Section 1135 telehealth waiver. Specifically, CMS has “advised” MA plans to waive or reduce cost-sharing for telehealth services and expand access to telehealth services in any geographic location and from a variety of places, including patients’ homes. Similar enforcement flexibilities have been granted to MA plans by OIG as under the traditional Medicare blanket waiver.

In addition, CMS has advised MA plans and Part D sponsors to:

- Waive cost-sharing for COVID-19 tests;
- Waive cost-sharing for COVID-19 treatments in doctor’s offices or emergency rooms;
- Remove prior authorization requirements;
- Waive prescription refill limits;
- Relax restrictions on home or mail delivery of prescription drugs.

The CMS guidance also applies to Medicare-Medicaid Alignment Initiative (MMAI) plans.