March 17, 2020

**CMS Suspends Certain Telehealth Coverage Requirements for COVID-19 Public Health Emergency**

Today, the Centers for Medicare and Medicaid Services issued guidance that explains its new temporary Telehealth Coverage Policies to help address the COVID-19 emergency situation.

CMS is using its 1135 waiver authority to expand telehealth benefits, effective March 6, 2020 until the end of the COVID-19 Public Health Emergency.

CMS is making changes to certain types of Medicare telehealth services for the duration of the COVID-19 Public Health Emergency. The [Fact Sheet](https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet) and [FAQ](https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf) documents released today are intended to describe the changes as well as provide a broad overview of the existing Medicare telehealth requirements in anticipation of many providers billing for telehealth services for the first time as a result of the changes.

There are three types of virtual services physicians and other professionals can provide to Medicare beneficiaries: **Medicare** **Telehealth Visits**, **Virtual Check-Ins** and **E-Visits**. CMS telehealth coverage changes apply differently to each of the three.

Most of the telehealth coverage changes apply to **Medicare** **Telehealth Visits**. The descriptions for **Virtual Check-Ins** and **E-Visits** are mostly informational. CMS is not proposing major changes to those programs.

Below is a summary that clearly describes how the new CMS telehealth coverage policies affect the different types of Medicare telehealth services.

1. **Medicare Telehealth Visits**

*\*\*A Telehealth Visit is not a colloquialism for telehealth services. It is a specific type of Medicare-covered telehealth with a specific set of Medicare requirements\*\**

Telehealth Visits are for a service that would typically have been provided in-person. CMS maintains a [list of services](https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes) that are normally furnished in-person that may be furnished via Medicare telehealth. These services are described by HCPCS codes and paid under the Physician Fee Schedule.

Suspending Originating Site Requirement

Normally, Telehealth Visits include an originating site and a distant site. CMS is waiving the requirement that the patient travels to an originating site for a telehealth service. Patients can receive telehealth services at their home.

Suspending Rural Requirement

Telehealth visits are normally limited to patients in rural areas. CMS is removing that requirement.

Preexisting Relationship with a Qualified Telehealth Provider

CMS is not changing the list of distant site practitioners (subject to state law) which can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals.

Some states require that telehealth services have to be furnished by a provider with whom the patient has a “prior relationship,” meaning the patient has received a Medicare service from that provider (defined at the TIN level) within the last three years. During the Public Health Emergency, CMS will not enforce the prior-relationship requirement for Telehealth Visits.

Communication Methods

Most telehealth services must continue to use an audio *and* visual communication method. The HHS Office of Civil Rights (OCR) is [relaxing the restrictions](https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html) on the type of audio-visual connection to allow Telehealth Visits using everyday communications technologies, such as FaceTime or Skype, regardless if those methods are HIPAA-compliant.

Telehealth Billing and Payment

CMS is not changing its telehealth billing requirements. Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

CMS is not requiring additional or different modifiers associated with telehealth services furnished under these waivers. However, consistent with current rules, there are three scenarios where modifiers are required on Medicare telehealth claims. In cases when a telehealth service is furnished via asynchronous (store and forward) technology as part of a federal telemedicine demonstration project in Alaska and Hawaii, the GQ modifier is required. When a telehealth service is billed under CAH Method II, the GT modifier is required. Finally, when telehealth service is furnished for purposes of diagnosis and treatment of an acute stroke, the G0 modifier is required.

Cost-sharing Waivers

In response to concerns that providers have to charge cost sharing for telehealth visits due to anti-kickback rules, the HHS Office of Inspector General [will not](https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/factsheet-telehealth-2020.pdf) enforce this [anti-kickback rule](https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf) for any services paid by Medicare, Medicaid or CHIP. Providers can reduce or waive cost-sharing for Telehealth Visits without penalty but they are also not required to do so.

1. **Virtual Check-In**

A Virtual Check-In is a brief (5-10 minutes) communication initiated by the patient with a practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. Virtual Check-In’s can occur regardless of if the patient is in a rural area.

Patients can communicate with their practitioner using a broad set of communication methods regardless of audio-visual capabilities, including telephone or other communication technologies. The practitioner can respond to the patient’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal.

Virtual Check-In’s require an established patient relationship. CMS is not waiving this requirement for Virtual Check-In’s during the Public Health Emergency.

These virtual check-ins cannot be related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available).

There are two Virtual Check-In codes:

* HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
* HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.

1. **E-Visits**

Broadly speaking, E-Visits are virtual evaluation and management (EM) services. They are similar to Virtual Check-Ins in that the patient must initiate the E-Visit, an established relationship is required, and the patient does not have to be located in a rural area. E-Visits can also occur in the patient’s home.

E-Visits are different than Telehealth Visits because they must occur through an online patient portal.

Medicare pays for E-visits to practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) under the following codes:

* 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
* 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes
* 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.

Clinicians who may not independently bill for evaluation and management visits (e.g., physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:

* G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
* G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
* G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

**Medicaid and States**

This policy applies specifically to Medicare’s coverage of telehealth. CMS did issue additional [guidance to states](https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf) recommending how Medicaid programs can align with Medicare’s policies. Many commercial payers are voluntarily taking action to expand the availability of these services but those decisions are up to states and individual payers.