ALSTON & BIRD

TO: Health Care Clients

FROM: Alston & Bird LLP

DATE: March 18, 2020

RE: Telehealth Waiver and Remote Care Guidance

FEDERAL TELEHEALTH GUIDANCE

Under the current federal Section 1135 blanket waivers for telehealth[1] as of March 18, 2020, CMS has waived the following:

- **Originating Site**. Typically, Medicare reimburses for telehealth services only when they are provided to beneficiaries in one of nine (9) eligible originating sites (plus the home for ESRD clinical assessments or substance use disorder treatment and mobile stroke units for telestroke), and only when that originating site is in a health professional shortage area outside of a Metropolitan Statistical Area (MSA) or a county that is not included in an MSA. 42 C.F.R. § 410.78(b)(3)-(4). Effective for services starting March 6, 2020, both of these requirements have now been waived for the duration of the public health emergency, permitting **Medicare to reimburse for telehealth services provided to any location, anywhere** in the emergency area, which currently encompasses the entire U.S. Note that only the listed eligible originating sites may bill for the originating site facility fee (HCPCS Q3014)
    - **Pre-Established Patient Requirement (Will Not Be Audited)**. Under the statutory language, providers may operate under this waiver only when the practitioner (or another practitioner within his/her practice, as determined by the tax ID number) has seen the patient within the last 3 years and billed the service to Medicare. However, under the coronavirus spending package expected to be approved by Congress this week, that requirement may be changed such that the patient must have been seen by the practitioner (or another within his/her practice) within the last 3 years for any service that would normally be covered by Medicare (regardless of whether it was billed or whether the patient was a Medicare beneficiary at the time). CMS has announced that it will not be auditing the pre-existing patient requirement during this public health emergency, which in effect, nullifies this requirement.

- **Telephone Use**. Typically, Medicare requires a two-way, real-time, interactive telecommunication between the patient and the distant site practitioner, and the regulation specifically excludes the use of telephones. 42 C.F.R. § 410.78(a)(3). However, the current waiver permits the use of telephones to provide Medicare-reimbursable telehealth services, provided the phone has real-time audio-video capabilities. Although not a reimbursement requirement, this would generally also require a secure, encrypted communications platform and a HIPAA-compliant business associate agreement with the technology vendor, but see the discussion below on HIPAA Privacy & Security Rule enforcement.

[1] https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

- **State Licensure**. Medicare will now reimburse for services provided by a practitioner to the emergency area (the entire U.S.) even if the practitioner is not licensed in that state or enrolled in Medicare in that jurisdiction, provided the practitioner holds the equivalent license in another state and is enrolled in Medicare where licensed, and is not excluded from practice in any state. Note that this does not affect state licensing requirements. Some states are beginning to loosen state licensure requirements, although providers may also consider contacting their state medical or professional licensing boards for additional guidance or to request a limited waiver.

These blanket waivers are available to all providers that bill Medicare. CMS has also issued guidance for Medicaid[2] and Programs of All-Inclusive Care for the Elderly (PACE) Organizations,[3] indicating that states and PACE Organizations have a great deal of flexibility with respect to furnishing services via telehealth.

In addition, federal agencies have issued guidance that they will exercise their enforcement discretion in the following matters:

- **Cost-Sharing for Telehealth Services**. The Office of Inspector General (OIG) has announced[4] that it will not subject practitioners to OIG administration sanctions for reductions or waivers of beneficiary cost-sharing obligations when they are reduced or waived for telehealth services. Normally, routine reductions or waivers of co-payments, coinsurance, and deductibles could subject the practitioner to penalties under the federal Anti-Kickback Statute and the prohibition on beneficiary inducements, but the OIG will use its enforcement discretion during the period subject to the current public health emergency.

- **HIPAA Privacy & Security Rule for Telehealth Services**. The Office for Civil Rights (OCR) has announced[5] that it will not impose penalties for noncompliance with HIPAA security requirements against practitioners who provide telehealth services in good faith during the current public health emergency. The telehealth service can be provided for any reason—related to COVID-19 or not—and can now take place over any number of popular applications that allow for video chat, including Apple FaceTime, Facebook Messenger, Google Hangouts, Skype, or other platform, without the practitioner risking penalties for noncompliance with HIPAA rules. OCR does, however, encourage practitioners to use all available encryption and privacy modes, and to notify patients that the applications may introduce privacy risks. Note also that the temporary relaxation of HIPAA rules applies to telehealth only, and it may be reasonable to conclude that it extends to other types of remote care via technology (such as virtual check-ins and e-visits, discussed below). However, HIPAA privacy and security rules still apply to other modalities of care and communications with patients, and otherwise remain fully in effect.

In summary, Medicare still requires these elements for a reimbursable telehealth visit under 42 C.F.R. § 410.78:

1. *Qualifying distant site practitioner* – one of the nine listed eligible practitioners.

2. ~~*Qualifying originating site type*~~ – currently waived.

[2] https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-telehealth-services.pdf.
[3] https://www.cms.gov/files/document/covid-19-pace-memo-3-17-20.pdf.
[4] https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf.
[5] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

3. ~~*Rural originating site*~~ – currently waived.

4. *Qualifying technology* – live, synchronous, audio-video connection.
    - Security requirements under HIPAA will not be enforced.
    - Use of a telephone is now permitted if the technology has the capability for live, synchronous audio-video communications. The statute and the waiver do not mandate that the audio-video capability is used, so there is a reasonable basis to conclude that a provider may utilize audio-only telephone communications to provide Medicare-reimbursable telehealth services, provided the system (the smartphone and the provider's platform) has the capability to use live A/V if needed, and the provider determines, within his or her professional judgment, that the audio-only telephone communication is clinically appropriate under the circumstances.

5. *Qualifying service* – represented by one of the listed telehealth eligible codes,[6] telehealth place of service code and any applicable modifiers.

Virtual Check-ins and E-Visits: In CMS's March 17, 2020 blanket waiver announcement for telehealth,[7] CMS also encouraged practitioners to consider utilizing "virtual check-ins" and "e-visits." These relatively new services, which became available to Medicare-enrolled practitioners in 2019 and 2020 respectively, technically are not considered "telehealth" by CMS, because they are inherently technology-based. The current CMS waivers do not affect the reimbursement requirements for these modalities. Note that:

- Virtual check-ins allow established Medicare patients in their home to have brief communications with their practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image, and are only available to practitioners who may independently bill for evaluation and management (E/M) services under CPT codes G2010 and G2012.
- E-visits allow established Medicare patients to have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals, and can be provided by both practitioners who may independently bill for E/M services under CPT codes 99421–99423, as well as those who may not (physical therapists, speech language pathologists, clinical psychologists) under HCPCS codes G2061-G2063.
- While the OIG non-enforcement of patient cost-sharing and the ONC non-enforcement of HIPAA rules specifically state that they apply to "telehealth" services (and virtual check-ins and e-visits technically are not considered telehealth), we believe that there is a reasonable legal basis to conclude that they should. First, the ONC's Notice of Enforcement Discretion also uses the term "communicate with patients…through remote communications technology." Second, both notices are clearly intended to provide practitioners with maximum flexibility for remote care during this public health emergency. We believe it is reasonable to conclude that the agencies intended to, and would if faced with the question, extend their enforcement discretion to any remote care, including virtual check-ins and e-visits.

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[6] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
[7] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.