TeamPraxis

Practice Cheat Sheet Series
March 20, 2020

Telehealth in response to the COVID-19 Public Health Emergency

Telehealth, telemedicine, and related terms generally refer to the exchange of medical information from one site to another through electronic communication to improve a patient's health. With the emergence of COVID-19, there is an urgency to expand the use of technology to help people who need routine care, and keep the vulnerable and those with mild symptoms in their homes while maintaining access to the care they need. Limiting community spread of the virus, as well as limiting the exposure to other patients and staff members will slow viral spread.[1]

Additional Benefits of Telehealth

- Accessible care for those in rural or isolated communities
- Readily available and convenient services for people with limited mobility, time or transportation options
- Increased access to specialists
- Support for self-management of health care
- Reduced cost of care

Considerations for Implementing Telehealth

- HIPAA-compliant environment (not required during emergency)
- Secure and reliable internet connection and AV equipment
- Workflows and processes for scheduling telehealth visits
- Training and scripting for your staff to appropriately direct and schedule patients for telehealth visits
- Appropriate professional liability and malpractice insurance

Friendly Reminders

Source: https://www.gillettechildrens.org/khm/covid-19-what-you-need-to-know

Have additional questions or need support implementing a telehealth strategy for your practice?

Contact your Business Manager or call 808-225-7606.

Key Takeaways for Telehealth during the COVID-19 Public Emergency

1. The expanded benefits for Medicare beneficiaries are valid from 3/6/20 until the emergency is declared over.
2. Telehealth benefits apply to all covered patients and are not limited to potential Coronavirus patients.
3. As part of CMS's virtual check-ins, a brief (5-10 min) check-in via telephone or other telecommunications device can be offered to decide whether an office visit or other service is needed.
4. Eligible HMSA providers can utilize HMSA's Online Care telehealth portal to see existing or new patients. To enroll or get additional information, email HOCInfo@HMSA.com.
5. It is not required that Medicare beneficiaries have a prior established relationship with a practitioner for claims submitted during this public health emergency.

Disclosure: This document is meant to serve as a resource guide. TeamPraxis does not represent HMSA, CMS or any other parties. Please consult with your payer partner to confirm their program details.

HMSA Online Care Reimbursement Rates

Physician Provider Reimbursement (HMSA's Online Care)				
Conversation Length	*Base Visit 10 Min*	*Short Ext. (+) 3 Min*	*Long Ext. (+) 5 Min*	*Max Visit 15 Min*
Commercial Plans	$46.00	$0	(+) $29.00	$75.00
Akamai Advantage	$46.00	$0	(+) $29.00	$75.00
HMSA Quest	$34.00	$0	(+) $12.50	$46.50

Specialist Provider Reimbursement (HMSA's Online Care)				
Conversation Length	*Base Visit 10 Min*	*Short Ext. (+) 3 Min*	*Long Ext. (+) 5 Min*	*Max Visit 15 Min*
Commercial Plans	$50.00	$0	(+) $32.00	$82.00
Akamai Advantage	$50.00	$0	(+) $32.00	$82.00
HMSA Quest	$34.00	$0	(+) $12.50	$46.50

Medicare Telehealth Guidelines

Type of Service	What is the Service?	HCPCS/CPT Code	Patient Relationship with Provider
Medicare Telehealth Visits	A visit with a provider that uses telecommunication systems between a provider and patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425-G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) • See Complete List [4]	For new* or established patients. *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.
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 of recorded video and/or images submitted by an established patient.	HCPCS code G2012 HCPCS code G2010	For established patients.
E-Visits	A communication between a patient and their provider through an online patient portal.	99421 G2061 99422 G2062 99423 G2063	For established patients.

Frequently Asked Questions

	HMSA [2]	Medicare [3]
What services can be provided via telehealth?	HMSA maintains updated policy criteria on qualifying services at: https://prc.hmsa.com/s/article/Telehealth-Services For providers participating in payment transformation, telehealth services are only paid when conducted in HMSA's Online Care Portal. For providers not participating in payment transformation, the telehealth service is generally covered if it would have been covered for an in-person encounter and is provided via real-time video conferencing.	CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth. This list is available here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
Who are the qualified providers eligible to furnish telehealth services?	Telehealth services can be provided by a licensed health care provider working within the scope of their practice.	Physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives can provide telehealth services. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services.
Are patients required to have an established relationship?	For PPO plans, telehealth may be used to establish a health care provider-patient relationship when a provider has a license to practice. For QUEST Integration and HMO plans, Telehealth may be used to establish a primary care provider (PCP)-patient relationship when a PCP has a license to practice in Hawaii and is in-network. In-network provider-patient relationships may be established via telehealth if the patient is referred by the patient's established PCP, unless excluded by the patient's health plan. Out-of-network telehealth services will only be covered if the health plan referral requirements of the patient's plan are met prior to the services being rendered.	No. Under the waiver included as part of the Coronavirus Preparedness and Response Supplemental Appropriations Act, it is not required that patients have a prior established relationship with a practitioner for claims submitted during this public health emergency.
What equipment or technology is required to provide telehealth services?	Telehealth services may be provided through one of the following methods, including but not limited to: real-time video conferencing-based communication; secure interactive and non-interactive web-based communication; and secure asynchronous information exchange to transmit patient medical information, including diagnostic quality digital images and laboratory results for medical interpretation and diagnosis.	Currently, CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication they qualify as acceptable technology. HHS Office for Civil Rights (OCR) will exercise enforcement discretion and waive 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.

Frequently Asked Questions

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How are providers reimbursed for telehealth services?	Providers offering services via HMSA's Online Care portal will be paid a FFS rate based on plan type, visit duration, and provider type. Payment varies between $34-$82. Providers not participating in payment transformation will be paid for telehealth services at the current standard fee schedule.	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.
How does a provider bill for telehealth services?	For providers not participating in payment transformation, telehealth services may be billed with place of service code 02. HMSA provides a summary of CPT codes that may be used for reporting telehealth services when appended by modifier 95 for CPT approved codes or modifier GT or GQ for CMS approved codes at: https://prc.hmsa.com/s/article/Telehealth-Services Alternatively, HMSA providers may provide telehealth services via HMSA's online platform, HMSA Online Care. This service is free to HMSA providers and does not require billing or claims processing.	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.
What is the cost to the patient?	For patients utilizing HMSA's Online Care portal, visit cost for HMSA members is $0-$15 based on plan type. Visit cost to non-HMSA members ranges from $59-$180 based on provider type.	The use of telehealth does not change the out-of-pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
Can patients check in with practitioners via telephone to decide whether an office visit or other service is needed?	Standard telephone contact, facsimile transmission, or email—in combination or individually—does not constitute a telehealth service and is not covered.	A brief (5-10 min) check-in via telephone or other telecommunications device can be offered to decide whether an office visit or other service is needed. Practitioners may also provide a remote evaluation of recorded video and/or images submitted by an established patient. These virtual check-ins are available for established patients and can be billed using HCPCS codes G2012 and G2010.

Sources:

[1] https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[2] https://prc.hmsa.com/s/article/Telehealth-Services

[3] https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

[4] https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes