

Quick Guide to Virtual Care

April 7, 2020

Getting Started

During the COVID-19 Pandemic, short-term telehealth capacity is critically important and facilitates a rapid response. However, due to this unplanned transformation of the health care system, this technology may become part of the new "normal" in the long-term. Seek expedience while keeping an eye on creating a sustainable delivery solution that can be scaled once the national emergency has been lifted.

Short-Term Solution

Do you need a solution that you can set up today while you work on a more long-term solution for telehealth needs?

CMS recently provided flexibility during the COVID-19 pandemic to waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies, such as audio-only telephone calls, FaceTime or Skype. ([See Appendix B](#))

Long-Term Solution

Telehealth capacity and utilization has never been more needed than now. The steps below are intended to help you and your organization better understand your telehealth needs as well as steps to consider in executing your telehealth plan.

Planning (Refer to this [implementation checklist](#))

1. Identify Telehealth Goal(s)

- a. What do you want to accomplish with the introduction of a telehealth delivery capacity? (e.g., keep both staff and patients safe, improve efficiency, conserve personal protective equipment, provide greater patient access, reduce team burnout, etc.,)
- b. Based on payment model, what disciplines on your staff would you like to utilize telehealth technology?
Your response identifies service size/scope.
 - Fee-for-Service
 - o Palliative Care (Medicare Part B - e.g., only physicians, physician and APRNs, etc)
 - o Hospice (Medicare A – face-to-face encounters and interdisciplinary team)
 - Value-Based—(e.g., physicians, APRNs, social workers, chaplains, etc.,)?
- c. What type of service do you want to provide? (e.g., synchronous only, synchronous and virtual check-in, etc.,)

2. What segment of your patient population would you like to target with telehealth services? Designate an IT/Service Manager

- a. Who on your team will manage the telehealth service? (e.g., coordinate platform selection and acquisition, develop telehealth policies and procedures, procure equipment and space, manage access, train staff, screen patients for telehealth capacity and appropriateness, collect and analyze data and patient/staff satisfaction, etc.,)

- b. How will the designated manager be supported by internal or external technology expertise? (e.g., evaluate individual connectivity options, provide access orientation for patients/caregivers, solve video conferencing issues, etc.,)

3. Screen the Target Population for Telehealth Capacity & Model Appropriateness

- a. What percentage of the target population is interested and/or can be convinced to receive some of their care through telehealth?
- b. What portion of the interested population is self-enabled or can be enabled through a caregiver/family member?
- c. What questions will you need to ask patients to determine their capacity and appropriateness for receiving care through telehealth? Is the patient willing to have face-to-face visits using a video conferencing (telehealth) approach? Does the patient have an applicable video conferencing device (i.e., a front-facing camera on a mobile telephone, tablet, laptop or desktop computer)?

4. Determine Applicable Telehealth Payor Requirements

- a. After Medicare, which payors, by percentage, insure the largest percentages of your target population?
- b. Which payors reimburse for delivery of telehealth services?
- c. How does each payor define telehealth, billable providers, necessary patient relationship, location of service, etc.? May these services be provided by Nurse Practitioners, Physician Assistants, and other Qualified Health care Providers (QHP)? How are telehealth visits to be billed?

Select A Technology Platform

1. Assess, Select and Acquire Telehealth Platform Access

- a. Do you want to buy a turnkey solution or build your own platform?
- b. Beyond video conferencing, what type of additional functions might you wish to integrate on the platform now or in the future? (e.g., peripheral devices [stethoscopes, blood pressure monitors, etc.,] remote patient monitoring tools, translation services, etc.,)
- c. What are important platform selection criteria? (e.g., HIPAA compliance, minimum staff and patient hardware and connectivity, upload and download capabilities, ease of use for both staff and patients, integration into existing workflow and EHR, maintenance and upgrade expenses, upfront and monthly costs, etc.,)
- d. Who are some of the many vendor solutions to consider? Do you have an existing relationship? Can your EHR vendor integrate telehealth?
- e. What hardware and connectivity will staff and patients need?

2. Acquire Necessary Staff & Patient Hardware and Connectivity

Implementation

1. Train Staff on Platform Use, Technical Problem Solving & Service Expectations (Use this [etiquette checklist](#))

2. Obtain Patient Authorization for Telehealth Usage and a Waiver for Other Forms of Communication

- a. What should be included in Telehealth Authorization Form that provides patient consent for this type of visit? (See Appendix A)
- b. What should be included in a Communication Waiver if a patient is willing to use unsecured means of communication? (See Appendix A)

3. Schedule Patient Visit and Provide Initial [Technology Orientation](#)

- a. What disciplines and individuals will need to be present for the visit?
- b. Who will schedule the visit and where will it be documented?
- c. Who will provide the initial technology orientation and instructions to the patient/caregiver and what will it contain? (See [Appendix C](#))
- d. How can no-shows be minimized, and access/technology problems solved?

4. Conduct & Document Visit

- a. What amount of time should be allocated for different types of visits? (the amount of allocated time should include the face-to-face encounter, care coordination, and charting of visit and time spent)
- b. How much time should be allocated between visits? (time for visit preparation should be built into each provider's visit schedule)

5. Code and Bill for Visit

- a. Face-to-Face Encounters
 - i. For hospice face-to-face encounters: The face-to-face encounter completed through telehealth should be documented as such. Since it is an administrative function, the visit is not billable.
 - ii. For medically necessary visits provided through telehealth during the hospice face-to-face encounter, the hospice should report the E/M code for the visit, using the 95 modifier. If the medically necessary visit is rendered by a nurse practitioner that has been elected as the hospice attending, add the GV modifier so that the Medicare Administrative Contractor (MAC) knows if the visit is to be paid at the ARNP rate (85% of the physician payment) rather than at the physician rate. The modifier 95 must be used for all telehealth services billed to Medicare.
- b. Virtual Visits on the Hospice Claim Form
 - i. Social worker phone calls can be added to the claim form for all phone calls to patients and families for social work services. Audio visual requirements do not apply, as this is a long-standing requirement for social work services.
 - ii. No other disciplines in hospice may enter telehealth visits on the claim form at this time.
- c. Documentation in the Electronic Medical Record (EMR)
 - i. Document all types of visits in the clinical record. If in person visits were not made, document attempts and reasons for managing care through virtual visits.
 - ii. Document the type of visit that will be completed to manage the patient care in the plan of care.
 - iii. The plan of care should reflect the plan for visits and how this plan is meeting the goals of care in a safe and appropriate manner

ACP Billing and Coding Telehealth: <https://www.acponline.org/practice-resources/covid-19-practice-management-resources/covid-19-telehealth-coding-and-billing-information>

CMS Telehealth Services: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLN-Products/Downloads/TelehealthSrvcsfctsht.pdf>

Coding during COVID-19 Resources: <https://codingintel.com/telemedicine-and-covid-19-faq/>

Pediatric Telehealth: https://www.aap.org/en-us/Documents/coding_factsheet_telemedicine.pdf

The number of steps and complexity of each may appear daunting, however many of the preceding steps can be accomplished simultaneously. If you need support, there are resources that are available:

General Provider Telehealth and Telemedicine Tool Kit:

<https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf>

OCR Enforcement Discretion on Telehealth Remote Communications (effective 3/17/2020):

<https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html>

NHPCO Edge Consultant: Franey & Associates Consulting, Inc.: <https://www.nhpco.org/edge>

Appendices

See Additional Resources

In an authorization form

- Acknowledgement of opportunity to participate in consultation through a virtual platform
- Acknowledgement that explanation provided of how videoconferencing technology will be used, and that such a consultation/visit will not be the same as an in-person patient/health care provider visit as I will not be in the same room as my health care provider.
- Understanding of potential risks to technology including interruptions, unauthorized access, and technical difficulties. Acknowledgement of ability that the individual or their healthcare provider can discontinue the telemedicine visit if it is felt that videoconferencing is not adequate for the situation.
- HIPAA information
- Alternatives to virtual visits
- Billing information
- The opportunity to ask questions about this technology; acknowledgement that questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with individual in a language in which they understand

In a communication waiver

- Include explanation of HIPAA compliance via approved platforms of communication (list)
- Understanding that alternative platforms may not protect personal information and are used at the patient's own risk if that is their preference (list)
- Acknowledgement statement including patient's selection of acceptable alternative unsecure communication platforms: text message, email, other _____
- Preference for Patient Experience Survey (if applicable): mail or email

Expanded access to telehealth services during the COVID-19 pandemic

2 April 2020

In response to the COVID-19 pandemic, the U.S. Congress, the Centers for Medicare and Medicaid Services (CMS), many state legislatures and state Medicaid programs, and private payers have implemented significant changes to restrictions on the provision and coverage of telehealth services. These changes are intended to make it easier for individuals to receive treatment remotely during the emergency in order to mitigate risk of exposure for both patients and health care workers, and reduce pressure on an increasingly strained health care infrastructure. The changes are analyzed in detail below.

The federal changes include provisions in the Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSA); last week's Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which we have [previously summarized here](#); the [Interim Final Rule \(IFR\)](#) issued by CMS on March 30 and published on March 31, 2020, and numerous guidance documents posted by CMS. Many of these federal regulatory changes expand the scope of Medicare Part A and Part B benefits available for the duration of the emergency period and, accordingly, impact both Medicare fee-for-service and Medicare Advantage organizations. In addition, earlier this week, CMS announced [blanket waivers](#) of certain federal laws and regulations for health care providers. Most of the changes discussed herein are temporary measures that apply only for the duration of the emergency period, which began on January 27, 2020 and will terminate when the Secretary of Health and Human Services (HHS) declares the end of the public health emergency related to COVID-19. The regulatory changes finalized in the IFR, which was effective March 31, are retroactive to March 1, 2020. Comments on the IFR are due June 1, 2020.

I. Changes to Medicare coverage and reimbursement for telehealth

Medicare beneficiaries can receive telehealth services without location or site restrictions

The CPRSA granted HHS the authority to temporarily waive Medicare telehealth restrictions that limit Medicare payment for telehealth services based on where the beneficiaries live and where they receive care. CMS implemented this [telehealth waiver authority](#) on March 17, effective as of March 6, 2020. Now, during the period of emergency, beneficiaries can receive telehealth services anywhere in the country, including in their own homes. And effective March 1, CMS's blanket waivers [also allow](#) physicians and certain other practitioners to render telehealth services from their homes without having to report their home address on their Medicare enrollment. Further implementation guidance is provided in the IFR and various guidance documents posted on the [CMS website](#).

Medicare will reimburse physicians and other practitioners for telehealth services as if the services were provided in person

Previously, under the Medicare telehealth benefit, the “originating site” where the beneficiary presented for services typically received a small facility fee, while the physician or other practitioner at the “distant site” billed the physician fee schedule rate for his/her services. CPRSA expands the locations where beneficiaries can receive telehealth services, but provides that sites not previously permitted as “originating sites” under the law (e.g., beneficiaries’ homes) are not eligible to receive a facility fee. In the IFR, CMS exercised its waiver authority to instruct physicians and other practitioners to bill for telehealth services using a place of service (POS) code as if the services were provided in person, and to use a new Current Procedural Terminology (CPT®)[1] telehealth modifier 95 to identify services furnished via telehealth.

CMS expanded the list of services that Medicare will cover when provided by telehealth, and removed certain frequency restrictions

In the IFR, CMS added, on an interim basis, over 80 CPT codes that are now eligible for reimbursement under Medicare when provided via telehealth. The addition of these codes will expand the ability of health care professionals to screen potential COVID-19 patients via telehealth instead of in person, and will permit the remote assessment and treatment of other patients to

reduce or eliminate the need for those patients to leave their homes or to visit hospitals or physician offices. In addition, on an interim basis, CMS removed frequency restrictions for certain codes.

Relaxation of requirements for telehealth technology

In the IFR, CMS clarified that, for the duration of the emergency period, Medicare will cover telehealth services when provided via technology that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communications between the patient and the distant site physician or practitioner. As noted below, the Office for Civil Rights (OCR), which enforces compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), also announced that it is exercising its enforcement discretion and will not impose penalties on covered health care providers in connection with the good faith provision of telehealth using common audio or video communication products that may not be fully HIPAA compliant.

In the IFR, CMS also finalized, on an interim basis, separate payment for certain CPT codes that generally describe audio-only communication between a practitioner and patient. CMS also announced that it will not enforce the requirement that certain of these codes be used only for established patients.

Medicare beneficiaries are not required to have a pre-existing relationship with the physician or other practitioner providing telehealth or related services in order to receive reimbursement

Section 3703 of the CARES Act further amended the telehealth emergency authority provision enacted in the CPRSA to remove a requirement that the physician or practitioner providing the telehealth service must have treated the beneficiary in the prior three years or be in the same practice as a physician or practitioner who treated the beneficiary in the same time period.

In the IFR, CMS stated that certain communication technology-based services (CBTS), such as virtual check-ins and remote monitoring, can be furnished to both new and established patients. CMS also specified that patient consent for such services can be obtained at the same time the service is rendered, and may be collected by auxiliary staff under general supervision rather than direct supervision.

Physicians and other practitioners are not required to hold licenses in the state in which they provide telehealth services for purposes of reimbursement under federal health care programs

Physicians and other practitioners are required to be licensed in the states in which they provide services for purposes of reimbursement under federal health care programs, and, in the case of telehealth services, that typically means they must be licensed where the patients they are treating are located at the time of treatment. On March 13, 2020, HHS [waived](#) the requirement that physicians or other health care professionals hold licenses in the state in which they provide services, if they have an equivalent and unrestricted license from another state, for such purposes. However, physicians and other practitioners must remain mindful of state licensure requirements that otherwise remain in effect, subject to state law waivers or orders as discussed below.

Physicians and non-physician practitioners may provide direct supervision using real-time interactive audio and video technology

In the IFR, CMS revised the definition of direct supervision to allow, for the duration of the emergency period, direct supervision to be provided using real-time interactive audio and video technology. Prior to the IFR, direct supervision has meant that the physician must be present in the office suite and immediately available to furnish assistance during the procedure. However, for the duration of the emergency period, physicians can meet the direct supervision requirement by virtual presence using audio/video real-time communications that allows the physician to be immediately available to furnish assistance.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) can serve as distant sites for telehealth services under Medicare

Section 3704 of the CARES Act allows FQHCs and RHCs to serve as telehealth distant sites and receive reimbursement for services provided to eligible beneficiaries during the emergency period. Section 3704 further specifies that FQHCs and RHCs will be reimbursed for such telehealth services at payment rates similar to the PFS.

Use of telehealth in the home health setting

In the IFR, CMS amended regulations to allow, for the duration of the emergency period, home health agencies to use technology in conjunction with the provision of in-person visits provided the telehealth visits meet certain requirements.

Telehealth in skilled nursing facilities

CMS is [waiving](#) the requirement for physicians and non-physician practitioners to perform in-person visits for nursing home residents and will allow visits to be conducted, as appropriate, via telehealth options.

Telehealth for hospice patients

To determine continued eligibility for hospice care, CMS requires periodic face-to-face visits between a hospice patient and a hospice physician or nurse practitioner. Section 3706 of the CARES Act permits these visits to be conducted by telehealth during the emergency period.

CMS also amended the hospice regulations, on an interim basis, to specify that routine home care visits provided to hospice patients may be done via telehealth if feasible and appropriate. The use of the technology must be included in the plan of care and tied to the patient-specific needs.

Telehealth in the Inpatient Rehabilitation Facility (IRF)

In the IFR, CMS encouraged rehabilitation physicians to continue in-person assessments as long as necessary precautions are taken; however, during the emergency period, CMS is temporarily allowing certain required face-to-face visits to be conducted via telehealth. Moreover, CMS is removing the post-admission physician evaluation requirement for all IRFs during the emergency period.

II. Changes to Medicaid coverage and reimbursement of telehealth services

CMS issued [guidance](#) to state Medicaid programs that included, among other things, a reminder that states have broad flexibility to cover telehealth through their Medicaid programs, including through various methods of communication (such as telephonic, video technology commonly available on smart phones and other devices). Although no federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for face-to-face services, a state plan amendment (SPA) would be necessary to accommodate any revisions to payment methodologies for telehealth costs if the state wants to receive federal matching funds for increases in payments under its state plan delivery system.

CMS also encouraged states to amend Medicaid Managed Care (MMC) contracts, as needed, to extend the same telehealth flexibilities authorized under their state plan, waiver, or demonstration for services covered under the contract. Absent coverage under the state plan or otherwise through a Medicaid waiver or demonstration, CMS noted that MMC plans may rely on offering telehealth services as value-added services or as alternatives to other services, subject to ongoing compliance with certain regulatory requirements.

III. Changes to other federal laws related to the provision of telehealth services

Certain HIPAA requirements waived for telehealth services during emergency period

HHS OCR [announced](#) that it is exercising its enforcement discretion and will not impose penalties on covered health care providers for noncompliance with HIPAA and its implementing regulations in connection with the good faith provision of telehealth services using common, non-public facing audio or video communication products such as FaceTime, Google Hangouts, or Skype during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, not just related to the diagnosis and treatment of health conditions related to COVID-19.

Physicians and other practitioners may reduce or waive cost-sharing amounts owed by federal health care program beneficiaries for telehealth services

On March 17 and March 24, 2020, the HHS Office of Inspector General (OIG) released [policy statements](#) indicating that during the emergency period it will not seek administrative sanctions against physicians and other practitioners who reduce or waive any cost-sharing amounts owed by federal health care program beneficiaries for telehealth services and other non-face-to-face services such as virtual check-ins, remote care management and remote patient monitoring. In addition, on March 30, the OIG [announced](#) it would exercise enforcement discretion to offer flexibility for health care providers to provide goods and services necessary to respond to the pandemic without fear that their conduct will be subject to enforcement under the rules that would ordinarily apply, including with respect to telehealth services, which we previously [summarized here](#).

Practitioners registered with the Drug Enforcement Agency (DEA) may issue prescriptions for controlled substances to patients via telehealth

On March 16, 2020, the Acting DEA Administrator [activated](#) the public health emergency exception in the Controlled Substances Act to allow DEA-registered practitioners to prescribe controlled substances via telehealth rather than an in-person evaluation if (1) the prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice; (2) the telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system; and (3) the practitioner is acting in accordance with applicable federal and state laws.

IV. Certain changes to state licensure and other state laws to facilitate telehealth

In addition to the many federal program changes related to telehealth services, state legislatures, medical boards and other state agencies have taken steps to encourage or facilitate the use of telehealth within their states. These state actions include: waiving requirements for physicians and certain other health care practitioners to be licensed in the state in order to provide telehealth services to a patient in the state, provided they hold a valid license in another state; granting temporary licenses to physicians and other health care practitioners already licensed in another state; and waiving licensure fees, continuing education and background check requirements. On March 24, 2020, HHS sent a [letter](#) to state governors asking them to modify regulatory and legal requirements around licensure, standard of care, scope of practice, supervision requirements, licensure and certification requirements, student practice and malpractice insurance in an attempt to free up resources. Some states have temporarily revised their statutes and regulations to expand the types of services that can be provided by telehealth or waive certain restrictions, such as requirements for having first established an in-person patient relationship. Some states have even waived requirements that telehealth services be provided through equipment allowing real-time audio and video interaction, and have allowed audio-only (telephone) communications to qualify as telehealth in some circumstances.

Note that even with CMS's waiver of the Medicare requirement that telehealth providers must be licensed in the state in which the patient is located, providers still must ensure they are in compliance with applicable state licensure requirements.

V. Certain changes to private payer coverage of telehealth

While private payer policies regarding coverage and reimbursement of telehealth services have always varied a great deal, many insurers have announced policy changes to make telehealth services more widely available and affordable. Many insurers have expanded the list of services that they will cover when provided by telehealth, and many have made telehealth services available without any cost sharing to their insureds for a limited period of time, or for certain services, such as screening and assessment related to COVID-19.

* * *

Federal and state actions regarding the use of telehealth to provide services during the COVID-19 pandemic are ongoing, and laws and implementation guidance are expected to continue to evolve. Should you have questions about the changes to the restrictions on the provision and coverage of telehealth services, please do not hesitate to contact the Hogan Lovells attorney with whom you regularly work or any attorney listed on this alert.

Authored by Brooke Bumpers, Sheree Kanner, Ken Choe, Stuart Langbein, Melissa Bianchi, Beth Roberts, Thomas Beimers, Craig Smith, Beth Halpern, Margaux Hall, and Laura Hunter

[1] CPT Copyright 2020 American Medical Association (AMA). All rights reserved. CPT® is a registered trademark of the AMA.

Contacts



Brooke Bumpers

Counsel

Washington D.C.

brooke.bumpers@hoganlovells.com



Sheree Kanner

Partner

Washington D.C.

sheree.kanner@hoganlovells.com



Ken Choe

Partner

Washington D.C.

ken.choe@hoganlovells.com



Stuart Langbein

Partner

Washington D.C.

stuart.langbein@hoganlovells.com



Melissa Bianchi

Partner

Washington D.C.

melissa.bianchi@hoganlovells.com



Beth Roberts

Partner

Washington D.C.

beth.roberts@hoganlovells.com



Thomas Beimers

Partner

Washington D.C.

thomas.beimers@hoganlovells.com



Craig Smith

Partner

Miami

craig.smith@hoganlovells.com



Beth Halpern

Partner

Washington D.C.

elizabeth.halpern@hoganlovells.com



Margaux Hall

Partner

Washington D.C.

margaux.hall@hoganlovells.com



Laura Hunter

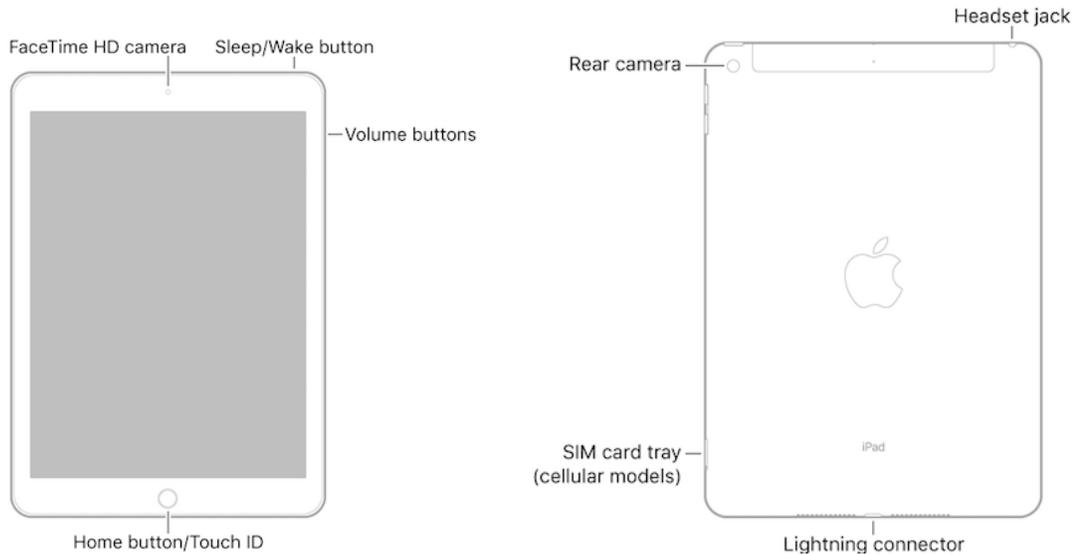
Associate

Washington D.C.

laura.hunter@hoganlovells.com

© 2019 Hogan Lovells. All rights reserved. "Hogan Lovells" or the "firm" refers to the international legal practice that comprises Hogan Lovells International LLP, Hogan Lovells US LLP and their affiliated businesses, each of which is a separate legal entity. Attorney advertising. Prior results do not guarantee a similar outcome.

Resolution Care
707-442-5683
517 3rd street Ste.22 Eureka Ca 95501



Turn On iPad

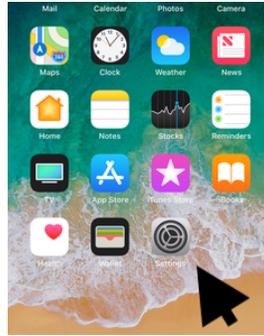
1. Power on iPad by pressing the On/Off button at the top right for 3 seconds.
2. Enter your passcode when prompted.
3. Sleep iPad by briefly pressing the On/Off button.
4. To wake iPad, briefly press the On/Off button.
5. To turn off iPad, press and hold the On/Off button until the 'slide to power off' appears.

Wi-Fi Built-in Connection

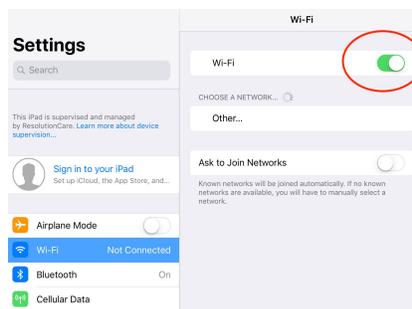
If you don't have internet service, you will be using the built in functionality of iPad to access the internet. No configuration or set up is necessary.

If you have a home internet Wi-Fi connection, you will need to configure iPad to connect to it. You will need to know the name and password of your wi-fi network.

1. Tap the Settings App.



2. Tap Wi-Fi and tap the on/off switch so it is to the right.



4. In 'Choose A Network...' window, tap on the name of your wi-fi network. A pop-up will appear, enter your password in the text window and tap Join on the keyboard or upper right corner.



Resolution Care
707-442-5683
517 3rd Street Ste.22 Eureka Ca 95501

Zoom VideoConference

You will be provided a Meeting ID number by a Resolution Care team member in advance of your scheduled videoconference.

1. Tap the Zoom icon to launch the App.



2. Tap on the Join a Meeting button.



3. Enter the meeting ID, your name and tap Join. Join with device or internet audio, allow use of camera and microphone if prompted

4. When the meeting has ended you may be returned to the Start a Meeting screen. Tap the home button once to return to the Home Screen.

Resolution Care
707-442-5683
517 3rd Street Ste.22 Eureka ca 95501

You have been provided a data enabled Apple iPad 6 Generation tablet, as well as a power adapter and charging cable.



Keep It Charged

You do not need to keep iPad connected. However, be sure to charge iPad for at least 2 hours prior to your meeting. You can also use iPad while it is connected.