OneCare Vermont

Vermont Medicare Accountable Care Organization Initiative

Telehealth Expansion Waiver

Guidance Document
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CARES Act Waiver Update

The Coronavirus Aid, Relief, and Economic Security (CARES) Act is the emergency funding passed in response to the outbreak of COVID-19 in March 2020. The stimulus package addresses topics such as healthcare delivery, state funding, small business and non-profit relief and overall economic stimulus. Due to the CARES Act and its impact on healthcare delivery systems, Medicare waiver participants should shift billing practices to those in alignment with the codes outlined in the CARES Act.

How to Use this Guidance Document

This guidance document was developed by OneCare Vermont (OneCare) to inform, educate, and offer tools to successfully implement and use the Telehealth Expansion Waiver (Telehealth Waiver) in Health Service Areas (HSA) participating in the Vermont Medicare Accountable Care Organization (ACO) Initiative program. This document will be updated as new information is made available from the Centers for Medicare & Medicaid Services (CMS). This document, along with other Telehealth Waiver materials and OneCare patient attribution lists, are available in the OneCare Secure Portal.

A Brief Overview of Telehealth and Telemedicine

What is telehealth?

Telehealth refers to the methods for healthcare service delivery using telecommunications technologies. The term telehealth is often used to describe the electronic telecommunications technologies that enable long-distance clinical healthcare. These technologies include two-way, real-time, audio and video interactive communication, and occur through a secure connection that complies with HIPAA. Telehealth includes telemedicine.

What is telemedicine?

Telemedicine is the healthcare service(s) delivered by a provider who is located at a distant site to a beneficiary at an originating site for purposes of evaluation,

diagnosis, consultation, and/or treatment using telecommunications technology. The term "telemedicine" is sometimes used interchangeably with "telehealth."

Telehealth telecommunication technologies are organized into two types:

Synchronous Telehealth: Real-time, audio-video communication technologies that connect providers and patients in different locations, ("live, real-time, or face-to-face"). This can include the use of interactive videoconferencing and mobile health (mHealth) applications on computers or hand-held devices.

Asynchronous Telehealth: Recorded health history and exams are stored and transmitted ("store-and-forward") through a secure electronic communications system to a provider who then uses the medical information to evaluate the patient, interpret health information, and render a clinical service and/or diagnosis. This can include remote-patient monitoring tools and devices that collect and communicate biometric data to providers and mHealth applications. Asynchronous telecommunication systems do *not* include telephone calls, fax transmissions, or text messages.

Overview of the Telehealth Expansion Waiver

In traditional fee-for-service Medicare, telehealth services are limited to rural Health Professional Shortage Areas (HPSA), CMS defined telehealth originating sites at health facilities, and synchronous telehealth services only.

The Medicare Telehealth Expansion Waiver specifically:

- eliminates the rural geographic component of originating site requirements,
- expands the definition of originating site to include an ACO attributed Medicare *patient's home*, and

- allows for the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology.

The Waiver does *not* expand the list of currently covered telehealth services, nor does it cover normal costs associated with telemedicine services. Under the Waiver, "originating site" refers to the location *the patient is physically located* when the telehealth service is delivered. Originating sites include, but are not limited to, the following settings:

- physicians' or practitioners' offices
- hospitals
- clinics and federally qualified health centers (FQHCs)
- hospital-based renal dialysis centers (including satellite sites)
- skilled nursing facilities (SNFs)
- community mental health centers, and
- the patient's home, *inclusive* of long-term care residence and assisted living facilities.

It is important to assess the patient's ability to successfully use telehealth technology in the home. Please see the section *Additional Patient Requirements and Resources* for more information.

Provider Eligibility to Use the Waiver

Providers must be enrolled with OneCare as a Medicare Preferred Provider and be approved by CMS to bill under the terms of the Waiver. Under current program guidelines, the following providers are eligible to bill under the Telehealth Waiver:

- Physicians
- Nurse Practitioners (NPs)
- Physician Assistants (PAs)
- Nurse Midwives
- Registered Dieticians
- Clinical Nurse Specialists (CNSs)

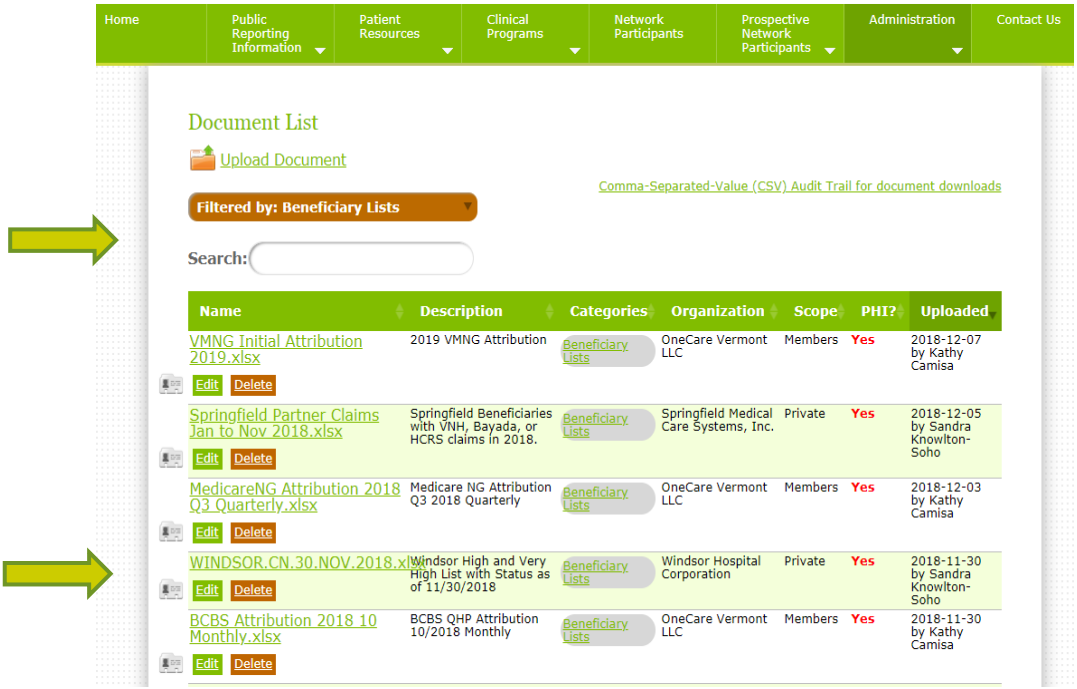
- Certified Registered Nurse Anesthetists
- Clinical Psychologists
- Clinical Social Workers
- Nutrition Professionals

Annually, participants and preferred providers are enrolled into the OneCare Vermont Network (Network). OneCare submits the list of all program participants and providers to CMS, and requests that all eligible Medicare providers be eligible to bill under the Telehealth Expansion Waiver. To confirm eligibility to use and bill under the Waiver, please contact the Medicare Waiver Administrator.

Patient Eligibility to Use the Waiver

A Medicare beneficiary must be attributed to OneCare to be eligible to use the Telehealth Waiver. Therefore, steps must be taken to verify the patient's attribution status *prior to* Waiver initiation. To verify attribution, the patient must be included in the Medicare beneficiary attribution list. Beneficiary attribution lists are available in the OneCare Secure Portal. The lists are updated quarterly (i.e. approx. 90-days), and released after the quarter of attribution.

OneCare Secure Portal Attribution Lists

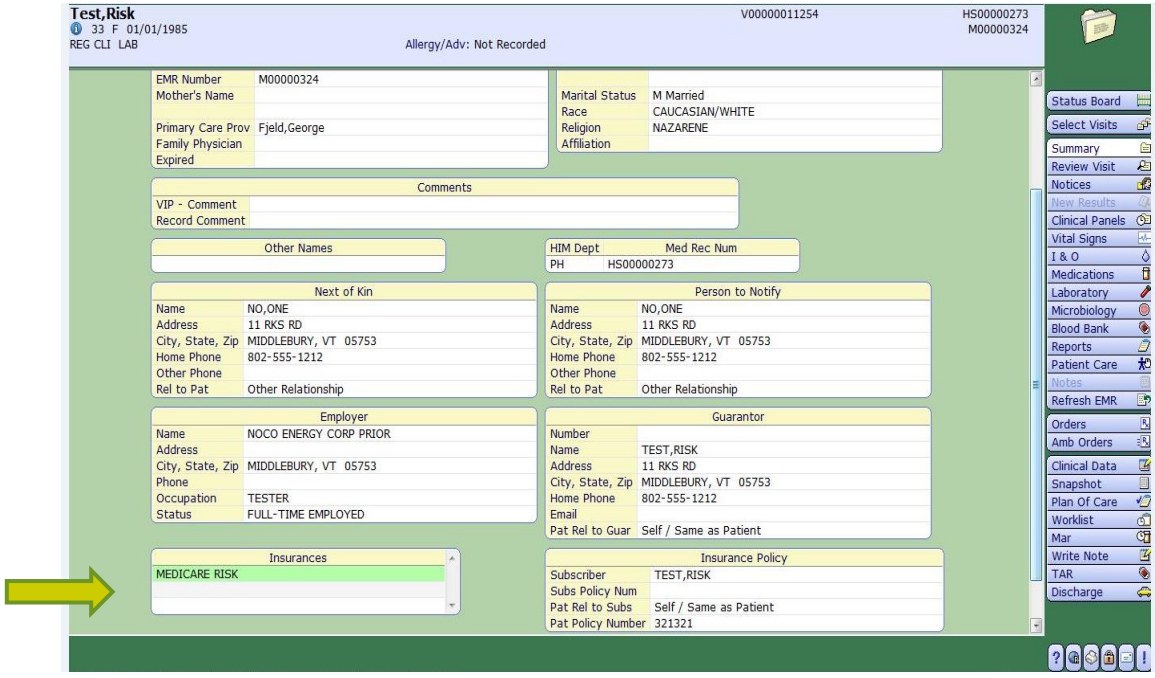


Within the Secure Portal, navigate to the "Administration/Documents" tab. Select "Beneficiary Lists" as the filter. Search for **Medicare Attribution**.

The 90-day delay in patient attribution list updates does not impact the process of confirming patient attribution as the Telehealth Waiver has a built in **90-Day Grace Period for Excluded Beneficiaries**. This grace period allows a former Medicare attributed patient who was aligned to the ACO at the start of the *performance year*, but who is later excluded from attribution during the *performance year*, to be eligible for the Waiver provided that admission occurs within 90 days following the date of the alignment exclusion and all other eligibility requirements of the Waiver are met. **This grace period applies only within a performance year.** Therefore, at the beginning of a new performance year, you will need to use the new year's attribution list. If you have questions about the 90-Day Grace Period, please contact the Medicare Waiver Administrator.

One suggestion to assist facilities in confirming patient attribution is to build an icon or data field into your Electronic Health Record (EHR). Below is a screen shot of patient demographic page in a Meditech EHR. Notice in the bottom left hand corner, in the Insurances box, "Medicare Risk" is highlighted indicating that the patient is attributed to the Vermont ACO Medicare Initiative.

Patient Attribution Identification in EHR Example



Additional Patient Requirements and Resources

In Vermont, patient consent to received telehealth and telemedicine services must be received prior to the commencement of such services. While OneCare reminds providers of this requirement, we cannot provide legal guidance as to the parameters of patient consent. Please consult with your practice's legal counsel for specifications around patient consent documentation to receive telehealth/telemedicine services.

All patients admitted under the Telehealth Waiver require the same medical documentation as in traditional telehealth and telemedicine. Utilization of *CareNavigator*, a care coordination software platform, is suggested for use to communicate and to develop a shared care plan for patients, please see *OneCare Data Resources* in a later section of this manual for more information.

The University of Vermont Health Network (UVMHN) Telemedicine Program has made available their "Technology Assessment for In-Home Telemedicine Appointments" form to OneCare enrolled participants and providers to use as an informational template in the drafting of similar documents related to telehealth services, please contact the Medicare Waiver Administrator for more information.

In addition, the UVMHN Telemedicine Program is available for consultation and information for healthcare providers on how to best implement telehealth/telemedicine services, including equipment suggestions, specialty practices, and best practices.

Billing and Coding for the Telehealth Waiver *UPDATE due to CARES Act

*Due to the COVID-19 pandemic, participants should use the CARES act telehealth blanket waiver coding guidelines instead of those associated with the ACO Medicare telehealth waiver. CARES act waiver codes can be found here.

Billing, coding, and claims submission under the Telehealth Waiver can found in the CMS produced ***CMS Telehealth Expansion Waiver Frequently Asked Questions (FAQ)***; the latest version is available for download in the OneCare Secure Portal.

Coding for the Telehealth Waiver

The following Evaluation/Management (E/M) HCPCS codes are eligible for billing under the Telehealth Waiver:

Synchronous HCPCS codes for new patients:

G9481: Remote E/M 10 mins.

G9482: Remote E/M 20 mins.

G9483: Remote E/M 30 mins.

G9484: Remote E/M 45 mins.

G9485: Remove E/M 60 mins.

Synchronous HCPCS codes for established patients:

G9486: Remote E/M 10 mins.

G9487: Remote E/M 15 mins.

G9488: Remote E/M 25 mins.

G9489: Remote E/M 40 mins.

Asynchronous HCPC codes:

G9868: Remote dermatologic and/or ophthalmologic imaging less than 10mins.

G9869: Remote dermatologic and/or ophthalmologic imaging 10-20mins

G9870: Remote dermatologic and/or ophthalmologic imaging 20mins or more

Long descriptors for codes and additional billing information for submitting Waiver claims can found in the CMS produced Vermont All Payer Model Telehealth Expansion Waiver Frequently Asked Questions (FAQ), available for download in the OneCare Secure Portal.

OneCare Data Resources

OneCare Secure Portal

A secure OneCare participant only internal website with financial, patient attribution lists, and network information.

CARE NAVIGATOR

A secure care management software system that supports greater alignment and integration in the work of complex care coordination in our network. CareNavigator is designed to support quality care management, population health, and improved outcomes by utilizing a single and secure platform that supports communication, shared care planning and collaboration among care team members.

Workbench One™

An innovative population health data platform powered by up-to-date clinical and claims data. Workbench One utilizes Advanced Analytics Applications ("Apps") that allows it's users to generate timely utilization and financial queries and reports across provider, practice, patient(s) and clinical service.

To request access to or training on OneCare Data Resources, please email:
helpdesk@onecarevt.org

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