Telemedicine Regulatory and Reimbursement Waivers Granted to Providers in Light of Pandemic

In response to the COVID-19 public health emergency, federal and state authorities have granted health care practitioners significant flexibilities to offer telemedicine services to their patients.

Medicare Expansion

The Coronavirus Preparedness and Response Supplemental Appropriations Act permits the Department of Health and Human Services to waive certain Medicare telemedicine payment requirements and allow beneficiaries in all areas—even those outside of rural areas—to receive services in any setting. This includes patients at home and in long-term care nursing facilities.

During this emergency, Medicare is reimbursing for telemedicine services, when appropriate, for the diagnosis and treatment of any condition, including most behavioral health, physical therapy and early intervention services. Both urgent and non-urgent visits are covered.

Previously, the Centers for Medicare & Medicaid Services (CMS) required that providers conduct telemedicine visits with their patients through specific HIPAA-complaint audio and visual telecommunication technologies. However during the public health emergency period, providers can use everyday communication technologies for these Medicare visits such as FaceTime, Skype, Facebook Messenger or Zoom, and will not risk HIPAA penalties due to enforcement flexibility.

Telemedicine in the Commonwealth

Virginia was a pioneer in requiring reimbursement for telemedicine services. In 2010, Section 38.2-3418.16 was added to the Code of Virginia requiring insurers to cover "telemedicine services" which extends beyond services provided by physicians. In 2019, language was added to mandate Virginia Medicaid cover telemedicine services.

During the pandemic Virginia's Department of Medical Assistance Services (DMAS) has also waived specific provider requirements for Medicaid coverage. For example, DMAS allows providers to use audio-only, or telephonic, connections in addition to audio-visual connections. Confidentiality and security requirements remain however.

DMAS has also relaxed the requirement that provider staff must be with the patient at the originating site in order to bill DMAS for the originating site facility fee.

Telemedicine in the home is permissible, but no originating site fee is paid. Submitted claims must use the appropriate CPT or HCPCS code as well as specified modifiers.

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Providers are reimbursed at the same rate as the analogous service provided face-to-face.

Appropriate documentation should support medical necessity for using the telehealth model chosen, as well as to support medical necessity for the ongoing delivery of the service through that model of care. Additionally, the following should be noted in the health record:

- Confirm patient is in Virginia for licensure purposes, and verify the patient location
- Note provider location
- Note the encounter was conducted via telemedicine
- Indicate the start/stop time
- Note patient consent
- Identify other providers, family members and individuals present during the service

The Virginia Board of Medicine issued guidelines on telemedicine services a number of years ago. These have been updated recently. They also have issued guidelines for nurse practitioners who provide telemedicine services. It is important to heed these guidelines as failure to do so can impact a provider's license.

In addition, most states require providers be licensed in the state where the patient is located for telemedicine services. Therefore it is important providers establish where the patient is located before rendering care to ensure the provider has the necessary license.

Telemedicine provides patients access to care while minimizing the likelihood of viral exposure or spread. Health care providers are hoping the regulatory flexibility remains after the health emergency is over, but that remains to be seen.

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