

# Next Generation ACO Model Telehealth Expansion Waiver

May 2021

Currently, in traditional fee-for-service Medicare, use of the telehealth benefit is limited to rural Health Professional Shortage Areas (HPSA<sup>1</sup>), [CMS defined telehealth originating sites](#), and synchronous telehealth services, with exceptions for certain diagnoses and services.<sup>23</sup> The Bipartisan Budget Act of 2018 further eased telehealth constraints for ACO participants operating under two-sided risk models. The Next Generation ACO Telehealth Expansion Waiver eliminates the rural geographic component of originating site requirements and allows the originating site to include a beneficiary's home for Preferred Providers. The waiver also allows for the use of asynchronous telehealth services in the specialties of teledermatology and teleophthalmology for Next Generation Participants or Preferred Providers. The waiver applies only to beneficiaries aligned to a Next Generation ACO and for services furnished by a Next Generation Participant or Preferred Provider approved to use the waiver.

An aligned beneficiary will be eligible for the Telehealth Expansion Waiver if the beneficiary is located at their home or one of the Centers for Medicare & Medicaid Services (CMS) defined telehealth originating sites.

This document provides frequently asked questions and answers related to the Telehealth Expansion Waiver. The first section includes questions around waiver policy, and the second section describes questions around data submission requirements.

## Frequently Asked Questions

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### Q1: **What telehealth services are covered by Medicare?**

A: Medicare currently covers a limited number of Part B services delivered by an approved provider to a Medicare beneficiary. The beneficiary must be located in an approved "originating site" and services must be delivered by face-to-face consult using live video conferencing technology. For a list of 2019 and 2020 Medicare Telehealth Services, see <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

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### Q2: **What is an originating site under existing Medicare telehealth rules?**

A: An originating site is the place where the patient is located when the telehealth service is provided. Approved originating sites include the following<sup>4</sup>:

- Physicians' or practitioners' offices

<sup>1</sup> For information on HPSAs, visit <https://bhw.hrsa.gov/shortage-designation/hpsas>.

<sup>2</sup> For more information about exceptions, consult the mln booklet on telehealth services: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcstsh.pdf>

<sup>3</sup> This does not incorporate the CMS expansion of telehealth due to Coronavirus disease 2019.

<sup>4</sup> For more information about exceptions, including the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, consult the mln booklet on telehealth services: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcstsh.pdf>

- Hospitals and Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)<sup>5</sup>
- Skilled nursing facilities (SNFs)
- Community Mental Health Centers (CMHCs)
- Renal dialysis facilities
- Homes of beneficiaries with end-stage renal disease (ESRD) getting home dialysis
- Mobile stroke units

**Q3: Who can bill for providing telehealth services?**

A: Only the following providers can receive reimbursement for delivering care using telehealth technology:

Physicians	Clinical nurse specialists (CNSs)
Nurse practitioners (NPs)	Certified registered nurse anesthetists
Physician assistants (PAs)	Clinical psychologists
Nurse midwives	Clinical social workers
Registered dietitians	Nutrition professionals

**Q4: What billable services can be provided using synchronous telehealth technology at an originating site that is not a beneficiary's home?**

A: The existing telehealth HCFA (Healthcare Financing Administration) Common Procedure Coding System [HCPCS]/Current Procedural Terminology [CPT] codes<sup>6</sup> delivered via synchronous telehealth are reimbursable by Medicare for the Next Generation ACO Model Telehealth Expansion Waiver as long as services are delivered by an approved provider to a patient located at an approved originating site (that is not a beneficiary's home).<sup>7</sup>

**Q5: What billable services can be provided using the waiver for synchronous telehealth technology at a beneficiary's home or place of residence?**

A: The following services (and HCPCS/CPT codes) delivered via synchronous telehealth are reimbursable by Medicare as long as they are delivered by an approved provider. Note that G-codes G9481–G9485 should be used for *all* telehealth services delivered in the home; the one exception is annual wellness visits, which should be billed using G0438 or G0439. No other G-codes or CPT codes should appear on the claim line for telehealth services delivered in the home.

HCPCS Code Numbers: G9481 – G9485

<sup>5</sup> Independent renal dialysis facilities do not qualify as originating sites.

<sup>6</sup> CPT (Current Procedural Terminology) Copyright Notice

Throughout this FAQ, we use CPT codes and descriptions to refer to a variety of services. We note that CPT codes and descriptions are copyright 2017 American Medical Association. All Rights Reserved. CPT is a registered trademark of the American Medical Association (AMA). Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations (DFAR) apply.

<sup>7</sup> The complete list of services, with descriptions, is available here: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsvcsfctshst.pdf>.

- **Long Descriptor:** Remote in-home visit for the evaluation and management of a *new* patient for use only in the Medicare-approved CMMI model, which requires these 3 key components:
  - A problem focused history;
  - A problem focused examination; and
  - Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, time is spent with the patient or family or both via real time, audio and video intercommunications technology
- **Short Descriptors:**

G9481: Remote E/M new pt 10 mins. G9482: Remote E/M new pt 20 mins. G9483: Remote E/M new pt 30 mins.	G9484: Remote E/M new pt 45 mins. G9485: Remote E/M new pt 60 mins.
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HCPCS Code Number: G9486 – G9489

- **Long Descriptor:** Remote in-home visit for the evaluation and management of an *established* patient for use only in the Medicare-approved CMMI model, which requires at least 2 of the following 3 key components:
  - A problem focused history;
  - A problem focused examination;
  - Straightforward medical decision making, furnished in real time using interactive audio and video technology. Counseling and coordination of care with other physicians, other qualified health care professionals or agencies are provided consistent with the nature of the problem(s) and the needs of the patient or the family or both. Usually, the presenting problem(s) are self-limited or minor. Typically, time is spent with the patient or family or both via real time, audio and video intercommunications technology.
- **Short Descriptors:**

G9486: Remote E/M est pt 10 mins. G9487: Remote E/M est pt 15 mins.	G9488: Remote E/M est pt 25 mins. G9489: Remote E/M est pt 40 mins.
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- Work and MP RVUs equal to those of the corresponding office/outpatient Evaluation and Management (E/M) visit CPT Codes: 99201 – 99215

HCPCS Code Number: G0438 – G0439

- **Long Descriptors:**
  - G0438: Annual wellness visit; includes a personalized prevention plan of service (PPPS); first visit
  - G0439: Annual wellness visit; includes a personalized prevention plan of service (PPPS); subsequent visit
- **Short Descriptors:**

**Q6: Can a Medicare Annual Wellness Visit be provided using telehealth in a non-HPSA (i.e., non-rural or urban) area or to a beneficiary in their home?**

A: Yes. A provider can use the existing HCPCS codes (G0438 and G0439) to bill the Annual Wellness Visit when the services were provided via telehealth in a non-HPSA (i.e., non-rural or urban) area clinical setting or when the Annual Wellness Visit was provided in the beneficiary's home. In either case, the claim should include the Place of Service (POS) code 02, which indicates the service was provided using telehealth. See Q5 above for more detail about billing for Annual Wellness Visits delivered to beneficiaries at home.

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**Q7: How does this waiver differ from what is currently covered by Medicare, for synchronous telehealth services?**

A: This waiver does not expand the list of covered services for synchronous telehealth. The waiver extends the use of synchronous telehealth services for Preferred Providers in two distinct ways: (1) the originating site (where the patient is located at the time of service) does not have to be in a rural HPSA area; and (2) the list of approved originating sites has been expanded to include the patient's place of residence (that is, home)

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**Q8: How do I bill synchronous telehealth waiver services?**

A: Telehealth service providers should follow the Medicare fee-for-service rules by using the appropriate POS and HCPCS or CPT code to indicate the professional service was delivered using synchronous (that is, real-time) technology. For further detail regarding reporting telehealth services, see the Medicare Claims Processing Manual, Pub. 100-04, chapter 12, section 190.3, available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>.

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**Q9: Which POS code should be used when the originating site is the beneficiary's home?**

A: POS 02 (telehealth) should be used for most synchronous telehealth services reported by physicians or practitioners (that is, the distant site provider). More information about this guidance is available in the 2018 Physician Fee Schedule (<https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf>). POS 12 (beneficiary's home) should be used when the beneficiary's place of residence was the originating site (applicable to all NGACO telehealth billing codes G9481 – G9489). Annual Wellness Visits (G0438 – G0439) are exceptional, in that they are billed with POS 02 when the beneficiary's place of residence was the originating site.

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**Q10: If the Bipartisan Budget Act of 2018 allows for similar synchronous telehealth flexibilities as the Telehealth Expansion Waiver for NGACO participants, do we still need the NGACO waiver for synchronous telehealth expansion? Do we need to do anything differently?**

**A:** Starting in January of 2020, policy under The Bipartisan Budget Act of 2018 eased telehealth constraints for ACO participants operating under two-sided risk models. While this new telehealth authority is applicable to NGACO Participants, it does not apply to NGACO Preferred Providers. Participation Agreements and related appendices for 2020 have been updated to reflect these changes in underlying authority. NGACOs Participants and Preferred Providers should continue to implement telehealth expansion BEs and synchronous telehealth expansion in the same way you have in prior years with the model.

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**Q11: Can Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs) serve as telehealth distant site providers?**

**A:** No, FQHCs cannot serve as distant site providers, either under the waiver or under the new authorities provided by the Bi-Partisan Budget Act of 2018. Chapter 13, section 200 of the Medicare Benefit Policy Manual states that FQHCs and Rural Health Clinics (RHCs) cannot serve as distant sites for telehealth. The relevant language from this section is, "RHCs and FQHCs are not authorized to serve as a distant site for telehealth consultations, which is the location of the practitioner at the time the telehealth service is furnished, and may not bill or include the cost of a visit on the cost report. This includes telehealth services that are furnished by an RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract."<sup>8</sup>

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**Q12: What is asynchronous telehealth?**

**A:** Asynchronous telehealth technology is also known as store-and-forward technology. Distinct from synchronous telehealth services (also known as live, real-time, or face-to-face), asynchronous telehealth includes the transmission of recorded health history (for example, retinal scanning and digital images) through a secure electronic communications system to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time interaction. Asynchronous telecommunication systems in single media format do not include telephone calls, images transmitted via facsimile machines, and text messages without visualization of the patient (electronic mail). Photographs must be specific to the patients' condition and adequate for rendering or confirming a diagnosis or treatment plan.

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<sup>8</sup> See Medicare Benefit Policy Manual, chapter 13, section 200 for additional detail: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c13.pdf>.

**Q13: Are asynchronous telehealth services covered under this waiver?**

**A:** Yes. Secure Payment will be permitted for asynchronous telehealth in single or multimedia formats that is used as a substitute for an interactive telecommunications system for dermatology and ophthalmology services. Distant site practitioners will bill for these new services using new codes. The distant site practitioner must be a Next Generation Participant or Preferred Provider with the telehealth benefit enhancement selected in the Provider List Submission Tool.

<b>Code</b>	<b>Description</b>
G9868	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, less than 10 minutes
G9869	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 10-20 minutes
G9870	Receipt and analysis of remote, asynchronous images for dermatologic and/or ophthalmologic evaluation, for use under the Next Generation ACO model, 20 or more minutes

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**Q14: If a beneficiary is aligned to the ACO at the beginning of the performance year (PY), but later becomes excluded from ACO alignment, is there a grace period during which CMS would continue pay for a telehealth service for that beneficiary?**

**A:** Yes, a 90-day grace period applies to the telehealth expansion services for beneficiaries who are originally aligned to the ACO during the performance year and who subsequently become excluded during the same performance year. The grace period is not intended to cross performance years. For example, if a beneficiary is aligned for PY2019, but not PY2020, the grace period would not apply if the telehealth service occurred in PY2020. The grace period applies to telehealth services provided under the authority of the NGACO telehealth expansion waiver, and also through the authority of the Bipartisan Budget Act of 2018 (as indicated in the Participation Agreement, Appendix R). More information is available in the appendices of the NGACO participation agreement.

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**Q15: What is secure messaging and is this covered under the ACO telehealth waiver?**

A: Secure messaging is the use of a secure email server to electronically communicate directly with the patient. Secure messaging is not reimbursed by Medicare because it is considered an alternative to telephone calls between the patient and provider. However, this does not prohibit providers from using secure messaging if it is viewed as a more efficient means for communication.

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**Q16: If the ACO intends to use telehealth to support care coordination, are providers able to bill for these services?**

A: Yes, telehealth can be used to support care coordination, as long as services fall under one of the approved service codes and telehealth is used in accordance with current Medicare telehealth coverage rules and the Next Generation Model waiver. To use the waiver, Next Generation participants and preferred providers must be designated on the applicable list with the Telehealth Benefit Enhancement indicator and must be a type of Medicare-enrolled provider that can bill for the codes listed above.

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**Q17: Can facilities located in urban areas (that is, non-health professional shortage areas [non-HPSAs<sup>1</sup>] that are serving as an originating site (that is, where the beneficiary is located) bill Medicare for the facility fee payment?**

A: Yes. Facilities located in urban areas (that is, non-HPSAs<sup>1</sup>) that are serving as an originating site (where the beneficiary is located) can bill Medicare for the facility fee payment. ACOs that would like to add facilities for this purpose will indicate the Telehealth Expansion Benefit Enhancement for both physicians and facilities in the Provider List Processing Tool in order to allow physicians (and other professionals) to serve as the distant site practitioner and facilities to serve as the originating site.

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