

- All other virtual visits:
 - CPT code 99241 will be reimbursed for all other synchronous real-time virtual visits when billed with Place of Service 11.
 - If the visit is related to COVID-19, the above -mentioned ICD10 diagnosis codes (Z03.818 or Z20.828) are required to be billed and reimbursement will be without customer copay/cost-share.
 - If the virtual visit is not related to COVID-19, the ICD10 code for the visit should be billed and reimbursement will be made according to applicable benefits and related cost share.
 - No virtual care modifier should be billed.
 - This billing reimbursement and associated reimbursement applies to services submitted on CMS1500 claim forms or its electronic equivalent only.

b. United Healthcare

Effective immediately, UnitedHealthcare is expanding policies around telehealth services for their Medicare Advantage, Medicaid and commercial membership, making it even easier for patients to connect with their health care provider.

- Designated Telehealth Partners - Members can access their existing telehealth benefit offered through one of UnitedHealthcare's designated partners for free.
- Expanded Provider Telehealth Access - Effective immediately, for the next 90 days (through June 18, 2020), all eligible in-network medical providers who have the ability and want to connect with their patient through synchronous virtual care (live video conferencing) can do so. Member cost sharing will be waived for COVID-19 related testing through June 18, 2020.

UnitedHealthcare will also waive the Centers for Medicare and Medicaid's (CMS) originating site restriction for Medicare Advantage, Medicaid and commercial members, so that care providers can bill for telehealth services performed while a patient is at home. This change in policy is effective until June 18, 2020 but may be extended if necessary.

This policy change applies to members whose benefit plans cover telehealth services and will allow those patients to connect with their doctor through audio/video visits. Member cost sharing and benefit plans apply.

Until June 18, 2020, UnitedHealthcare will reimburse appropriate claims for telehealth services under the following codes:

- Commercial: For all UnitedHealthcare commercial plans, any originating site requirements that may apply under UnitedHealthcare reimbursement policies are waived so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. UHC will reimburse telehealth services, which are (1) recognized by CMS and appended with modifiers GT or GQ and (2) recognized by the AMA included in Appendix P of CPT and appended with modifier 95. Reimbursable codes can be found embedded in the reimbursement policy at [Telehealth and Telemedicine Policy](#).
- Medicaid: For all UnitedHealthcare Medicaid plans, any originating site requirements that may apply under UnitedHealthcare reimbursement policies are waived so that telehealth services

provided via a real-time audio and video communication system can be billed for members at home or another location. UnitedHealthcare Community Plan will reimburse telehealth services, which are: (1) recognized by CMS and appended with modifiers GT or GQ and (2) recognized by the AMA included in Appendix P of CPT and appended with modifier 95.

- Medicare Advantage: For all UnitedHealthcare Medicare Advantage plans, including Dual Eligible Special Needs Plans, any originating site requirements that may apply under Original Medicare are waived so that telehealth services provided via a real-time audio and video communication system can be billed for members at home or another location. All CPT/HCPCS codes payable as telehealth when billed with Place of Service 02 and the GQ or GT modifiers, as appropriate, under Medicare will be covered on our Medicare Advantage plans for members at home during this time. Standard plan copays, coinsurance and deductibles will apply. Codes that are payable as telehealth under Medicare Advantage can be found here: [cms.gov](https://www.cms.gov).

Additionally, for commercial, Medicare Advantage and some Medicaid plans, UnitedHealthcare already reimburses appropriate claims for several technology-based communication services, including virtual check-ins, which may be done by telephone, for established patients. These services are for established patients, not related to a medical visit within the previous 7 days and not resulting in a medical visit within the next 24 hours (or soonest appointment available). These services can be billed when furnished through several communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010). UnitedHealthcare will also reimburse for patients to communicate with their doctors using online patient portals, using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. Until June 18, 2020, UnitedHealthcare will extend this reimbursement to all Medicaid plans.

c. Aetna

Aetna has recently announced the following resources and enhancements to their plans as a result of the COVID-19 outbreak:

- If a provider requests testing related to COVID-19, Aetna will waive the patient's cost sharing.
- Aetna Commercial patients pay \$0 for covered telemedicine visits until June 4, 2020.
- Until further notice, Aetna is also expanding coverage of telemedicine visits to its Aetna Medicare members, so they can receive the care they need without leaving their homes. With this change and new flexibilities announced by the Centers for Medicare and Medicaid Services to help combat the virus, Aetna Medicare members can now see their providers virtually via telephone or video.
- Aetna is offering its Medicare Advantage brief virtual check-in and remote evaluation benefits to all Aetna Commercial members and waiving the co-pay.
- Care packages will be sent to Aetna patients diagnosed with COVID-19. Through Aetna's Healing Better program, Aetna Commercial and Medicare Advantage members will receive CVS items to help relieve symptoms as well as personal and household cleaning supplies to help keep others in the home protected from potential exposure. Providers should call the number on any Aetna patient's ID card to register a recently diagnosed patient.

- Patients won't have to pay a fee for home delivery of prescription medications from CVS Pharmacy.
- Aetna is extending its Medicare Advantage virtual evaluation and monitoring visit benefit to all Aetna members as a fully covered benefit.
- Aetna is waiving early refill limits on 30-day prescription maintenance medications for all Commercial members with pharmacy benefits administered through CVS Caremark.
- Aetna Medicare members may request early refills on 90-day prescription maintenance medications at retail or mail pharmacies if needed. For drugs on a specialty tier, we're waiving early refill limits for a 30-day supply.
- Through existing care management programs, Aetna will proactively reach out to patients who are most at-risk for COVID-19.

More information can be found on the Aetna website [here](#) and a complete list of approved behavioral health telemedicine services can be found [here](#).

II. Medicare

The Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility. These policy changes build on the regulatory flexibilities granted under the President's emergency declaration. CMS is expanding this benefit on a temporary and emergency basis under the 1135 waiver authority and Coronavirus Preparedness and Response Supplemental Appropriations Act. Under this new waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, 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. Below are some FAQs surrounding these new waiver guidelines:

I. What are the current waivers for telemedicine provided to Medicare beneficiaries?

Starting March 6, 2020, Medicare can pay for office, hospital, and patient location of residence visits furnished via telehealth across the country. A range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, will be able to offer telehealth to their patients. Additionally, 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.

II. Are Community Health Centers (e.g., FQHCs) eligible for reimbursement under Medicare telehealth rules?

Medicare issues reimbursement for originating sites (defined as the location of an eligible beneficiary at the time the telemedicine occurs) and distant sites (the location of the provider issuing the service via telemedicine). Community Health Centers (e.g., FQHCs and Rural Health

Clinics) can only act as the originating site for telehealth delivered services. The geographic and site limitations will still apply with only certain exceptions that were in place prior to COVID-19 emergency rules. Community Health Centers can utilize some of the technology enabled services to treat patients such as the virtual check-in and some of the chronic care management codes but not others like eConsult. For these technology enabled codes, CHCs will receive a fee-for-service rate, not the PPS rate.

a. What are the key takeaways from these waivers regarding “Medicare Telehealth Visits?”

- Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances, such as location of residence (*these visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits*).
- During this time period, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- More importantly for providers, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.
- HHS will not conduct audits to ensure that a prior relationship existed for claims submitted during this public health emergency.

b. What are the key takeaways from these waivers regarding “Virtual Check-Ins?”

- Virtual check-in services can only be reported when the billing practice has an established relationship with the patient (this is not limited to only rural settings or certain locations).
- Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.
- Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

c. What are the key takeaways from these waivers regarding “E-Visits?”

- These services can only be reported when the billing practice has an established relationship with the patient. (There are no geographic or location restrictions for these visits).
- Patients communicate with their doctors by using online patient portals.

- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, where appropriate.
- The Medicare coinsurance and deductible would generally apply to these services.

III. Where can I find more information on the Medicare Telehealth Waivers?

More information can be found on the following websites:

- [CMS Provider Fact Sheet](#)
- [Medicare Telehealth Frequently Asked Questions](#)
- [List of Payable Services under Medicare Telehealth](#)

III. DEA – Teleprescribing of Controlled Substances

On January 31, 2020, the Secretary of the Department of Health and Human Services issued a public health emergency (HHS Public Health Emergency Declaration). Telemedicine can now be used under the conditions outlined in Title 21, United States Code (U.S.C.), Section 802(54)(D). For as long as the Secretary’s designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.
- The practitioner is acting in accordance with applicable Federal and State law.

Provided the practitioner satisfies the above requirements, the practitioner may issue the prescription using any of the methods of prescribing currently available and in the manner set forth in the DEA regulations. Thus, the practitioner may issue a prescription either electronically (for schedules II-V) or by calling in an emergency schedule II prescription to the pharmacy, or by calling in a schedule III-V prescription to the pharmacy.

Important note: If the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a controlled substance after having communicated with the patient via telemedicine, or any other means, regardless of whether a public health emergency has been declared by the Secretary of Health and Human Services, so long as the prescription is issued for a legitimate medical purpose and the practitioner is acting in the usual course of his/her professional practice. In addition, for the prescription to be valid, the practitioner must comply with any applicable State laws.

IV. Ohio Medicaid Telehealth Guidelines

The Ohio Departments of Mental Health and Addiction Services (“OhioMHAS”) and Medicaid (“ODM”), in partnership with the Governor’s Office, have developed emergency rules to expand and enhance telehealth options for Ohioans and their providers. These rules were adopted/amended by the [Governor’s Executive Order 2020-05D](#). These rules will relax regulations so that more people can be served safely in their homes rather than needing to travel to addiction and mental health treatment centers and also seek to reduce pressure on Ohio hospitals. Both rules will be in effect for 120 days and become effective on March 9, 2020, the date the Governor declared an emergency to exist.

[OhioMHAS’s emergency rule](#), which will be codified in the Ohio Administrative Code at section 5122-29-31, creates additional flexibilities in the agency’s regulations governing interactive videoconferencing. [ODM’s emergency rule](#), which will be codified in the Ohio Administrative Code at section 5160-1-21, creates a new Medicaid telehealth rule that governs reimbursement policies for Medicaid providers rendering services through telehealth. While the OhioMHAS emergency rule applies to all community behavioral health providers certified by OhioMHAS, the ODM emergency rule only applies to individuals covered by Medicaid and their providers. ODM’s emergency rule will be implemented by Medicaid fee-for-service, Medicaid Managed Care Plans (MCPs), and MyCare Ohio Plans (MCOPs).

There will be no limitations on practitioner or patient site locations for Medicaid reimbursable services delivered via telehealth with the exception of patients who are located in a penal facility or a public institution as defined in rule 5160:1-1-03 of the Administrative Code. Patients can be in their own homes and any other locations while accessing care, and practitioners can also deliver services from their offices, homes, and other locations.

a. Key Takeaways from the OhioMHAS Emergency Rule

- Allows the definition of “interactive videoconferencing” to include asynchronous activities that do not have both audio and video elements. Some examples of these asynchronous activities include telephone calls, images transmitted via facsimile machine, and electronic mail.
- Allows both new and established patients to receive services through interactive videoconferencing, and explicitly states that no initial face to face visit is necessary to initiate telehealth services.
- Adds new behavioral health services that can be delivered via interactive videoconferencing. All the Medicaid changes apply to Medicaid fee-for-service (FFS), Managed Care Plan (MCP), and MyCare Ohio Plan (MCOP) services. OhioMHAS certified entities can bill Medicaid for delivering the following services via telehealth:
 - Evaluation and management of new and existing patients
 - Psychiatric diagnostic evaluation
 - Psychotherapy (individual, group, and family)
 - Psychological testing
 - Smoking cessation
 - Community psychiatric supportive treatment (CPST)
 - Therapeutic Behavioral Services (TBS) and psychosocial rehabilitation (PSR)
 - Please note: TBS group service – hourly and per diem, as defined in 5160-27-06, is *not* included in the list of services that can be billed to Medicaid when delivered via telehealth.
 - RN and LPN nursing services

- SUD assessment
- SUD counseling (individual, group, intensive outpatient group, and partial hospitalization group)
- SUD case management
 - While this rule is temporary, the inclusion of SUD case management will be made permanent as soon as possible and any provider who provided SUD case management by interactive videoconferencing during the omission period will be held harmless
- Assertive community treatment (ACT)
- Intensive home-based therapy (IHBT)
- Peer recovery support
- Behavioral health crisis intervention
- SBIRT (screening, brief intervention and referral to treatment)
- Practitioner services rendered to individuals in SUD residential treatment
- Specialized Recovery Services (SRS)
- All associated add on codes
- Outpatient hospital behavioral health (OPHBH) services will be allowed to the same extent they are allowed for OhioMHAS-certified providers.
- Eliminates the requirement that providers must receive written consent from the patient acknowledging the risks of telehealth. Instead, the provider must document that the client was provided with the risks and agreed to assume those risks.
- Incorporates by reference the [Office of Civil Rights' Notification of HIPAA Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#).

b. Key Takeaways from the ODM Emergency Rule

- Incorporates by reference the [Office of Civil Rights' Notification of HIPAA Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency](#).
- Creates a new telehealth rule that is in effect during any time period in which the Governor of the State of Ohio declares a state of emergency and when authorized by the Medicaid director. During this time period, 5160-1-21 supersedes Medicaid's other telehealth rule, 5160-1-18.
- Allows all individuals with Medicaid to receive telehealth services – regardless of the last time they had a face-to-face visit with their health care provider, and regardless of their status as a new or existing patient.
- Defines telehealth as activities that are synchronous involving real-time, interactive audio and visual communications, as well as activities that are asynchronous, and do not have both audio and video elements. Some examples of telehealth services include videoconferences, telephone calls, images transmitted via facsimile machine, and electronic mail. ODM is relying on the professional judgment of healthcare providers to determine the appropriate method of privately communicating with each patient.

- Allows Medicaid billing regardless of patient and practitioner locations, with the exception of patients residing in penal facilities or a public institution, as defined in rule 5160:1-1-03 of the Administrative Code.
- Allows a wide range of practitioners and provider organizations to bill Medicaid for telehealth services.
 - The following types of practitioners can render Medicaid-covered services under ODM's emergency telehealth rule:
 - Physicians
 - Podiatrists
 - Psychologists
 - Physician Assistants
 - Clinical Nurse Specialists (CNS), Certified Nurse-Midwife (CNW), and Certified Nurse Practitioners (CNP)
 - Dietitians
 - Independently licensed behavioral health practitioners, and supervised behavioral health practitioners and trainees, as defined in OAC Chapter 5160-8-05
 - Audiologists, audiologist assistants, and audiology aides
 - Occupational therapists and occupational therapist assistants
 - Physical therapists and physical therapist assistants
 - Speech-language pathologists, speech language pathology aides, and individuals holding a conditional license, as defined in section 4753.071 of the Revised Code.
 - Medicaid School Program (MSP) practitioners, as defined in OAC Chapter 5160-35
 - Practitioners affiliated with community behavioral health centers
 - The following provider organizations can bill Medicaid, MCPs, and MCOPs for services rendered using telehealth under ODM's emergency rule:
 - Independently practicing clinicians identified in the bulleted list above
 - Professional medical groups
 - Federally qualified health centers (FQHCs) and rural health clinics (RHCs)
 - Ambulatory health care clinics (AHCCS) as defined in OAC Chapter 5160-13, which include end-stage renal disease (ESRD) dialysis clinics, family planning clinics, outpatient rehabilitation clinics, primary care clinics, public health department clinics, and speech-language-audiology clinic
 - Outpatient hospitals
 - Hospitals delivering outpatient hospital behavioral health (OPHBH) services, including psychiatric hospitals
 - Medicaid School Program providers
 - Community behavioral health centers that are certified by OhioMHAS
 - Providers of applied behavioral analysis (ABA) billing through the MCPs
- Offers a wide range of medical and behavioral health services that can be billed to Medicaid when delivered through telehealth including (the full list can be found [here](#)):

- Evaluation and management of new and existing patients, not to exceed moderate complexity (i.e. evaluation and management levels 1-4)
- Inpatient or office consultations for new or established patients
- Mental health and substance use disorder evaluations and psychotherapy,
- Remote evaluation of recorded video or images
- Virtual check-ins by a physician or other qualified health care professional
- Online digital evaluation and management services
- Remote patient monitoring of physiologic parameters
- Occupational therapy, physical therapy, speech language pathology, and audiology services
- Medical nutrition services
- Lactation counseling provided by dietitians
- Psychological and neuropsychological testing
- Smoking and tobacco use cessation counseling
- Developmental test administration
- Follow-up consultation with a patient
- Services under the specialized recovery services (SRS) program
- Incorporates by reference OhioMHAS emergency rule changes to interactive videoconferencing for community behavioral health centers treating Medicaid consumers, and suspends several Medicaid requirements for specific community behavioral health services to be delivered face-to-face.

c. Allowable Telehealth Delivery Methods

Through the emergency rules, ODM and OhioMHAS are permitting the use both synchronous and asynchronous communications involving any combination of audio, video, and text. OhioMHAS and ODM are relying on the judgment of our healthcare professionals to decide the best mechanisms of private communication to appropriately treat their patients.

Paragraph (P)(2) of the OhioMHAS rule and paragraph (C) of ODM's emergency rule incorporates HIPAA-related directives of the Office of Civil Rights (OCR) at the Department of Health and Human Services (HHS) issued during the COVID-19 national emergency by reference. At this time, OCR's "Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency" says covered health care providers subject to the HIPAA rules may communicate with patients, and provide telehealth services, through remote communications technologies even though some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. The restrictions in the Notification apply, including:

- a) Providers can use any audio or video **non-public facing** remote communication product that is available to communicate with patients;
- b) Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and **should not** be used in the provision of telehealth by covered health care providers;

- c) Providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications; and
- d) Providers are to exercise professional judgment in the use of telehealth examinations.

d. Claims Submission

ODM will be announcing a future implementation date for system changes to support telehealth services that will be the same for Medicaid fee-for-service claims submission, MCPs, and MCOPs. Prior to the implementation date for the system changes, providers may either hold claims until the system changes are implemented or submit claims for telehealth services using existing billing guidance. **If providers choose to submit claims for telehealth service prior to implementation of the system changes, please note the it is very important for providers to continue to use the existing billing guidance.**

For example, providers **should NOT** add the GT modifier to services that are being added as new telehealth services under the emergency rules prior to the IT system implementation date. If the GT modifier is added to the new services prior to the implementation date of the system changes claims may be denied. Additionally, until the system changes are made, providers should continue to use allowable place of service codes in existing billing guidance when submitting claims. Providers must maintain documentation of services delivered via telehealth prior to and after the system changes are made.

After the system changes are implemented, to the extent possible, providers should comply with the new billing guidance for telehealth services. Providers should maintain documentation to support any exceptions to the billing guidance necessary to maintain access to services to individuals during the emergency.

Providers are also encouraged to carefully review Paragraph (E) of ODM's emergency rule, 5160-1-21, regarding submission and payment of telehealth claims. Of particular note:

- (1) The practitioner site may submit a professional claim for health care services delivered through the use of telehealth.
- (2) An institutional (facility) claim may be submitted by the practitioner site for the health care service through the use of telehealth. Services provided in a hospital setting may be billed in accordance with rule 5160-2-02 of the Administrative Code.
- (3) The practitioner site may submit a claim for a telehealth originating fee. If such a practitioner renders a separately identifiable evaluation and management service to the patient on the same date as the health care service delivered through the use of telehealth, the provider may submit a claim for the evaluation and management service and the telehealth originating fee.

e. Other Resources

- For questions related to changes to OhioMHAS interactive videoconferencing policy as well as questions related to clinical and technical implementation of telehealth, please e-mail COVID19BHTelehealth@mha.ohio.gov.
- Questions about the Medicaid coverage, billing, and reimbursement under the new policy can be submitted to BH-Enroll@medicaid.ohio.gov.
- Resources related to telehealth may be found at <http://mha.ohio.gov/coronavirus>.

V. Florida Telehealth Guidelines

Rules for providing healthcare services through telehealth in the state of Florida are found in [Florida Statutes 456.47](#). Florida's law is relatively expansive and all-encompassing when compared to the rest of the United States. "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration.

In response to the COVID-19 pandemic, on March 16, 2020, the State Surgeon General, Scott A. Rivkees, M.D., issued an emergency order resulting in the following expansion of the telehealth rules:

1. Allows valid and duly licensed out-of-state providers not licensed in Florida to provide telehealth services to patients in Florida without going through the state registration process.
2. Qualified physicians under Florida law may issue a physician certification only for an existing qualified patient with an existing certification that was issued by that qualified physician without the need to conduct a physical examination while physically present in the same room as the patient.
3. Physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses that have designated themselves as a controlled substance prescribing practitioner may issue a renewal prescription for a controlled substance listed as Schedule II, Schedule III, or Schedule IV only for an existing patient for the purpose of treating chronic nonmalignant pain without the need to conduct a physical examination of the patient.

For a more detailed review of Florida's telehealth law, please see the details outlined below:

Practice Standards

- Duty to provide services within professional scope of practice and prevailing professional standard of practice for a health care professional who provides in-person health care services to patients in Florida.

Use of Telehealth to Perform Patient Evaluation

- A telehealth provider may use telehealth to perform a patient evaluation. If a telehealth provider conducts a patient evaluation sufficient to diagnose and treat the patient, the telehealth provider is not required to research a patient's medical history or conduct a physical examination of the patient before using telehealth to provide health care services to the patient.

Prescribing Controlled Substances through Telehealth

- A telehealth provider may not use telehealth to prescribe a controlled substance unless the controlled substance is prescribed for the following:
 - The treatment of a psychiatric disorder
 - Inpatient treatment at a hospital
 - The treatment of a patient receiving hospice services
 - The treatment of a resident of a nursing home facility

Technology Not Allowed

- Audio-only telephone calls
- E-mail messages
- Facsimile

Record Requirement

- A telehealth provider shall document in the patient’s medical record the health care services rendered using telehealth according to the same standard as used for in-person services. Medical records, including video, audio, electronic, or other records generated as a result of providing such services, are confidential.

Eligible Providers

- Behavior analyst; Emergency medical technician; Paramedic; Acupuncturist; Physician; Osteopathic physician; Chiropractor; Podiatrist; Optometrist; Certified nursing assistant; Licensed practical nurse; Registered nurse; Advanced practiced registered nurse; Pharmacist; Dentist; Midwife; Speech language pathologist; Audiologist; Occupational therapist; Radiologic technologist; Respiratory therapist; Dietitian; Athletic trainer; Orthotist; Prosthetist; Pedorthist; Electrologist; Massage therapist; Medical physicist; Clinical lab personnel; Hearing aid specialist; Physical therapist; Optician; Psychologist; Clinical social worker; Mental health counselor; Psychotherapist; Marriage and family therapist

VI. SAMHSA 42 CFR Part 2 Guidance

In response to the Novel Coronavirus Disease (COVID-19) pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) has provided guidance to ensure that substance use disorder (“SUD”) treatment services are uninterrupted during this public health emergency. In light of the increased need for telehealth SUD services, and in some areas without adequate telehealth technology, providers are only able to offer telephonic consultations to patients. In such instances, providers may not be able to obtain written patient consent for disclosure of substance use disorder records. The prohibitions on use and disclosure of patient identifying information under 42 C.F.R. Part 2 would not apply in these situations to the extent that, as determined by the provider(s), a medical emergency exists.

Under 42 U.S.C. §290dd-2(b)(2)(A) and 42 C.F.R. §2.51, patient identifying information may be disclosed by a part 2 program or other lawful holder to medical personnel, without patient consent, to the extent necessary to meet a bona fide medical emergency in which the patient’s prior informed consent cannot be obtained. Information disclosed to the medical personnel who are treating such a medical emergency may be re-disclosed by such personnel for treatment purposes as needed.

Note that Part 2 does requires program to document certain information in their records after a disclosure is made pursuant to the medical emergency exception. Therefore, in order to comply with the Part 2 medical emergency exception, providers must make their own determinations whether a bona fide medical emergency exists for purposes of providing needed treatment to patients and appropriately document any actions taken.

VII. HIPAA Enforcement and Telehealth

Some of the technologies used to communicate with patients via telehealth, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules. As of the [Notification of Enforcement Discretion](#) released March 17, 2020, the Office for Civil Rights (“OCR”) at the U.S. Department of Health and Human Services (“HHS”) will exercise its enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients through everyday communications technologies during the COVID-19 nationwide public health emergency. This exercise of discretion applies to widely available communications apps, such as FaceTime or Skype, when used in good faith for any telehealth treatment or diagnostic purpose, regardless of whether the telehealth service is directly related to COVID-19. This Notification of Enforcement Discretion currently does not have an expiration date.

A health insurance company that pays for telehealth services is not covered by the Notification of Enforcement Discretion.

a. How will HHS enforce the HIPAA Privacy and Security Rules under waived telehealth rules?

A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19.

b. Where can health care providers conduct telehealth?

OCR expects health care providers will ordinarily conduct telehealth in private settings, such as a doctor in a clinic or office connecting to a patient who is at home or at another clinic. Providers should always use private locations and patients should not receive telehealth services in public or semi-public settings, absent patient consent or exigent circumstances. If telehealth cannot be provided in a private setting, covered health care providers should continue to implement reasonable HIPAA safeguards to limit incidental uses or disclosures of protected health information (PHI). Such reasonable precautions could include using lowered voices, not using speakerphone, or recommending that the patient move to a reasonable distance from others when discussing PHI.

c. What telehealth services are covered by the Notification of Enforcement Discretion regarding COVID-19 and remote telehealth communications?

All services that a covered health care provider, in their professional judgement, believes can be provided through telehealth in the given circumstances of the current emergency are covered by this Notification. This includes diagnosis or treatment of COVID-19 related conditions, such as taking a patient's temperature or other vitals remotely, and diagnosis or treatment of non-COVID-19 related conditions, such as review of physical therapy practices, mental health counseling, or adjustment of prescriptions, among many others.

d. What may constitute bad faith in the provision of telehealth by a covered health care provider, which would not be covered by the Notification of Enforcement Discretion regarding COVID-19 and remote telehealth communications?

OCR would consider all facts and circumstances when determining whether a health care provider's use of telehealth services is provided in good faith and thereby covered by the Notice. Some examples of what OCR may consider a bad faith provision of telehealth services that is not covered by this Notice include:

- Conduct or furtherance of a criminal act, such as fraud, identity theft, and intentional invasion of privacy;
- Further uses or disclosures of patient data transmitted during a telehealth communication that are prohibited by the HIPAA Privacy Rule (e.g., sale of the data, or use of the data for marketing without authorization);
- Violations of state licensing laws or professional ethical standards that result in disciplinary actions related to the treatment offered or provided via telehealth (i.e., based on documented findings of a health care licensing or professional ethics board); or
- Use of public-facing remote communication products, such as TikTok, Facebook Live, Twitch, or a chat room like Slack, which OCR has identified in the Notification as unacceptable forms of remote communication for telehealth because they are designed to be open to the public or allow wide or indiscriminate access to the communication.

e. Which technologies are allowed?

Technologies that MAY be used under the telehealth enforcement waiver that do not normally meet HIPAA requirements (providers are encouraged to notify patients that these third-party applications potentially introduce privacy risks, and providers should enable all available encryption and privacy modes when using such applications):

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

HIPAA compliant hosting providers that are also acceptable for telehealth (note that Business Associate Agreement should be signed wherever possible, though OCR will not impose penalties against covered

health care providers for the lack of a BAA with video communication vendors that relates to the good faith provision of telehealth services during the COVID-19 nationwide public health emergency):

- Skype for Business
- Updox
- VSee
- Zoom for Healthcare
- Doxy.me
- Google G Suite Hangouts Meet

Technologies that may NOT be used for telehealth services because they are public facing:

- Facebook Live
- Twitch
- TikTok
- Instagram

More information can be found on the [OCR FAQ Sheet](#).

VIII. HIPAA Enforcement Generally

a. May a covered entity share patient information without patient authorization in the course of treatment?

Yes. Under the Privacy Rule, covered entities may disclose, without a patient's authorization, protected health information about the patient as necessary to treat the patient or to treat a different patient. Treatment includes the coordination or management of health care and related services by one or more health care providers and others, consultation between providers, and the referral of patients for treatment.

b. May a covered entity share patient information without patient authorization to public health authorities responsible for ensuring public health and safety?

Yes. The Privacy Rule permits covered entities to disclose needed protected health information without individual authorization under the following circumstances:

- To a public health authority, such as the CDC or a state or local health department, that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability. A "public health authority" is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. For example, a covered entity may disclose to the CDC protected health information on an ongoing basis as needed to report all prior and prospective cases of patients exposed to or suspected or confirmed to have COVID-19.

- At the direction of a public health authority, to a foreign government agency that is acting in collaboration with the public health authority.
- To persons at risk of contracting or spreading a disease or condition if other law, such as state law, authorizes the covered entity to notify such persons as necessary to prevent or control the spread of the disease or otherwise to carry out public health interventions or investigations.
- With disaster relief organizations that, like the American Red Cross, are authorized by law or by their charters to assist in disaster relief efforts, for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition, or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

c. May a covered entity share protected health information with family, friends, or others involved in an individual's care and treatment? Is patient authorization required?

Yes. A covered entity may share protected health information with a patient's family members, relatives, friends, or other persons identified by the patient as involved in the patient's care. A covered entity also may share information about a patient as necessary to identify, locate, and notify family members, guardians, or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include, where necessary to notify family members and others, the police, the press, or the public at large.

The covered entity should get verbal permission from individuals or otherwise be able to reasonably infer that the patient does not object, when possible; if the individual is incapacitated or not available, covered entities may share information for these purposes if, in their professional judgment, doing so is in the patient's best interest. For patients who are unconscious or incapacitated, a health care provider may share relevant information about the patient with family, friends, or others involved in the patient's care or payment for care, if the health care provider determines, based on professional judgment, that doing so is in the best interests of the patient.

d. What level of information can be shared by a covered entity?

For most disclosures, a covered entity must make reasonable efforts to limit the information disclosed to that which is the "*minimum necessary*" to accomplish the purpose (this standard does not apply to disclosures to health care providers for treatment purposes). Covered entities may rely on representations from a public health authority or other public official that the requested information is the minimum necessary for the purpose, when that reliance is reasonable under the circumstances. For example, a covered entity may rely on representations from the CDC that the protected health information requested by the CDC about all patients exposed to or suspected or confirmed to have COVID-19 is the minimum necessary for the public health purpose. In addition, internally, covered entities should continue to apply their role-based access policies to limit access to protected health information to only those workforce members who need it to carry out their duties.

e. In an emergency, what sort of safeguards must be in place to protected patient information?

Covered entities must continue to implement reasonable safeguards to protect patient information against intentional or unintentional impermissible uses and disclosures. Further, covered entities (and business associates) must apply the administrative, physical, and technical safeguards of the HIPAA Security Rule to electronic protected health information.

f. Where can I find more information?

For more information on HIPAA during times of an emergency and subsequent response, please visit [this HHS Fact Sheet](#).

OCR has published a bulletin advising covered entities of further flexibilities available to them as well as obligations that remain in effect under HIPAA as they respond to crises or emergencies, please visit this [OCR guidance](#).

Guidance on BAAs, including sample BAA provisions, is available at [here](#).

Additional information about HIPAA Security Rule safeguards is available on [these guidelines](#).

HealthIT.gov has technical assistance on telehealth [here](#).

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4831-0020-3448, v. 1