General Telemedicine Guidelines

The previous Telemedicine Guidelines have been amended to reflect the current changes in light of COVID-19. The numbered paragraphs reflect what applied in New Jersey *before* COVID-19. Below each paragraph, we added a paragraph titled, "**COVID-19,"** that identifies the changes made to the original statutes and rules in light of COVID-19 by Medicare and New Jersey. **YOU MUST FOLLOW THE MORE STRICT RULE IF YOU HAVE A MEDICARE PATIENT. IF YOU HAVE A PRIVATE PATIENT, THEN YOU ONLY HAVE TO FOLLOW THE NEW JERSEY RULE.** In addition, at the end of this Guidance, we identify significant additional changes to telemedicine in **"Other COVID-19 Changes"** and **"COVID-19 Billing Changes."** All of these changes will expire when the public emergency expires.

There have been significant changes to both Medicare and New Jersey statutes and regulations besides telemedicine. For those additional changes, please contact Kay Klele, Esq. at 973-451-8451.

These guidelines are general and do not cover every aspect of Medicare and New Jersey statutes and regulations on telemedicine. This is not intended to provide legal advice and should you have any questions, please contact Kay Klele, Esq. at 973-451-8451, or contact your billing vendor for billing issues.

1. To engage in telemedicine, you will need the following, as further explained below: (A) a proper license – the provider must be licensed in the state where the patient is located; (B) secure communication technology; (C) written protocols to address fraud and abuse; and (D) written policies to address privacy issues.

   COVID-19: See Below

2. **Equipment**: Any equipment used to acquire and transmit images, diagnostics, data, and medical information, which allows for the patient to be evaluated without being physically present, should be asynchronous store-and-forward. What does this mean? The licensee must use technology that allows for the electronic transmission of medical information, such as digital images, documents, and videos through secure email communication or a secure portal. To the extent you need to consult with a specialist, the technology should allow you to forward the medical data to another provider through a secure email communication or secure portal. Suggestion: Work with a consultant to obtain the correct technology.

   COVID-19: Medicare and New Jersey have not relaxed the rules on the type of equipment needed to exchange medical records, images, etc. However, as noted below, Medicare and New Jersey have relaxed their rules so that licensees can provide audio-only visits without the need for video equipment.

3. **Standard of Care**: Before each telemedicine or telehealth appointment (the "Appointment"), a licensee shall determine whether providing services through telemedicine or telehealth would be consistent with the standard of care applicable for those services when provided in-person. If the licensee determines that he or she cannot meet the standard before the Appointment, then the provider must inform the patient to obtain services in-person. If the licensee determines at any time during the Appointment that he or she cannot meet the standard, then the licensee must stop the Appointment and inform the patient to obtain services in-person.

COVID-19: Medicare and New Jersey have not relaxed the standard of care.

4. **Establishing a Licensee-Patient Relationship**: Before providing services through telemedicine or telehealth, a licensee must have an established licensee-patient relationship. If a licensee seeks to provide telemedicine services to a never seen before patient (i.e., a new patient), then the licensee can establish a licensee-patient relationship through telemedicine. To establish that relationship through telemedicine before the Appointment, the licensee shall:

    a. identify the patient with, at a minimum, the patient's name, date of birth, phone number, and address. A licensee may also use a patient's assigned identification number, Social Security number, photo, health insurance policy number, or other identifier associated directly with the patient. Suggestion: The licensee should use his or her intake forms for this purpose and send those forms before the Appointment. In fact, you should ask these patients to fill out the same forms you asks patients to fill out who physically come to the office;

    COVID-19: Medicare and New Jersey still require a licensee to obtain this information and the patient can provide the information to the licensee verbally if the patient cannot fill out intake forms. If the information is taken orally, then the licensee must document this information in the medical record.

    b. review the patient's history and any available records before the initial Appointment;

    COVID-19: Medicare and New Jersey have temporarily waived the requirement that a licensee review a patient's medical records prior to an initial telehealth encounter. Thus, the unavailability of records is not a barrier to the establishment of a proper licensee-patient relationship. However, the licensee should try to obtain as much information as possible from the patient to satisfy the standard of care.

    c. provide to the patient the identity, professional credentials (license number, title, specialty and board certifications) of the licensee who shall provide the telehealth and telemedicine services to the patient;

    COVID-19: This was not requirement under Medicare, but it is a requirement under New Jersey and it has not been waived.

    d. have the patient execute the informed consent; and

    COVID-19:

    Medicare: A licensee can receive annual consent, and that consent may be obtained at the same time or before the time that services are furnished. If written consent is unavailable due to technological challenges, the licensee should verbally explain the consent to the patient, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained.

    New Jersey: A patient may give written consent and may do so in a digitized format. The patient can also provide verbal consent. In either circumstance, the licensee should verbally

explain the consent with the patient, obtain the beneficiary's verbal consent, and document in the medical record that consent was obtained.

e. provide the patient the opportunity to sign a consent form that authorizes the licensee to release records of the encounter to the patient's primary care provider or other health care provider identified by the patient. Suggestion: The licensee should use his or her intake forms for this purpose and send those forms before the Appointment.

COVID-19: This is not a Medicare requirement, but it is a requirement under New Jersey and it has not been waived. If a patient would like the medical records transferred to another provider, the licensee should attempt to obtain the patient's request in writing.

5. **Review Medical Records**: As mentioned above, if a licensee does not have an established licensee-patient relationship, then the licensee must review any history and records, if any, before the Appointment. For any subsequent interactions with the patient, the history and records shall be reviewed either before the Appointment or during the Appointment with the patient.

COVID-19: See 4(b) above

6. **Use of Video Conference**: A licensee must use interactive, real-time, and secure two-way audio and visual communication technologies, which allows a licensee to see and hear a patient and the patient to see and hear the licensee. "One Exception" (Only NJ): If, after accessing and reviewing the patient's records, the licensee determines that he or she is able to meet the standard of care for such services, as if they were provided in person, without using the video component, then the licensee may use interactive, real-time, two-way audio-only in combination with asynchronous store-and-forward technology, without a video component. In other words, you can use a phone or other two-way audio communication without a video, but it has to be in combination with asynchronous store-and-forward technology to view images, diagnostics etc. while the licensee is speaking to the patient. Again, work with your consultant to make sure you have the correct technology information.

COVID-19:

Medicare: A licensee can use a telephone with audio-only, but Medicare does not consider this telemedicine so a licensee must bill using audio-only telephone billing codes. (See Below for Medicare Billing Changes). As a result, the "One Exception" above does not apply to Medicare. However, CMS and OCR have expanded the audio and video technology that a licensee can use to conduct a telemedicine visit to include telephones with both audio and visual capabilities. Thus, a licensee can now use the following *non-public* facing platforms: Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, and Skype. A licensee, however, cannot use the following *pubic-facing* platforms: Facebook Live, Twitch or Tik Tok, and Periscope.

New Jersey: The "One Exception" above allows a licensee to use an audio-only telephone in combination with asynchronous store-and-forward technology to review medical records, images, etc. while on the phone with a patient. In light of COVID-19, New Jersey is allowing licensees to use just an audio-only telephone call as telemedicine without asynchronous store-

and-forward technology. A licensee can also use the expanded audio and visual non-public facing platforms allowed by CMS and OCR noted above.

Bottom Line: Medicare does not allow a licensee to bill audio-only services as telemedicine, but New Jersey does allow it so a licensee has to be mindful of the patient's insurance. If a licensee has a Medicare patient, and uses audio-only, the licensee must use the audio-only codes and not the telemedicine codes.

7. **Prescriptions**: A licensee cannot issue a prescription to a patient based solely on responses provided to an online questionnaire, unless the licensee has a proper licensee-patient relationship as explained above. A licensee cannot prescribe Schedule II controlled dangerous substances until after an initial in-person examination of the patient, and a subsequent in-person visit with the patient every three months for the duration of time that the patient is being prescribed the Schedule II controlled dangerous substance. One exception: The in-person examination or review of a patient shall not be required, when a health care provider is prescribing a stimulant which is a Schedule II controlled dangerous substance for use by a minor patient under the age of 18 as long as (a) the licensee is using interactive, real-time, two-way audio and video technologies when treating the patient and (b) the licensee has first obtained written consent for the waiver of these in-person examination requirements from the minor patient's parent or guardian.

COVID-19 Changes for Medicare and New Jersey:

Normally, a practitioner must have a DEA registration in each State the practitioner is dispensing a controlled substance. In light of COVID-19, a DEA-registered practitioner in all areas of the United States may issue prescriptions for all Schedule II-V controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met: (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. *A licensee must determine whether the law of the State in which the patient is located has also loosened its laws to allow a licensee to treat the patient and prescribe controlled substances via telemedicine.*

If the prescribing practitioner has previously conducted an in-person medical evaluation of the patient, the practitioner may issue a prescription for a CDS after having communicated with the patient via telemedicine, or any other means, so long as the prescription is issued for a legitimate medical purpose, the practitioner is acting in the usual course of his/her professional practice, and the practitioner complies with applicable federal and state laws.

For New Jersey, any out-of-state practitioners licensed in New Jersey via the accelerated temporary licensure process established in response to COVID-19 need not hold a New Jersey CDS registration in order to prescribe CDS in New Jersey, so long as they (1) hold an active DEA registration in good standing in their home state; (2) have the authority to prescribe medications, including CDS, in their home state; (3) prescribe CDS consistent with the scope of practice for the applicable health care profession under New Jersey law and regulations; and (4)

such licensees register with New Jersey's Prescription Monitoring Program and comply with all applicable laws and rules when prescribing CDS or human growth hormone under the authority of their New Jersey temporary license.

8. **Contact Information**: During the Appointment, and after the provision of services, a licensee, or another designated licensee, shall provide his or her name, professional credentials, and contact information to the patient. Such contact information shall enable the patient to contact the licensee for at least 72 hours following the provision of services, or for a longer period if warranted by the patient's circumstances and accepted standards of care. Suggestion: After the Appointment, provide the patient with the informed consent because it contains the contact information. The licensee should also provide the information of any back-up licensees.

   COVID-19: This is not a Medicare requirement, but it is a requirement under New Jersey and it has not been waived. However, the licensee can provide the information verbally.

9. **Recording the Encounter**: A licensee must maintain a record of the Appointment and the medical records must comply with N.J.A.C. 13:35-8.16, and all other applicable State and Federal statutes and regulations. In other words, a licensee should record the same information in a medical record that a licensee would for an in-person visit, but a licensee must make clear in the medical record that it was a telemedicine or telehealth visit and identify the location of the patient.

   COVID-19: Medicare and New Jersey have not relaxed the medical records requirements.

10. **Fraud and Abuse Prevention**: To prove that a licensee made a good faith effort to prevent fraud and abuse regarding telemedicine or telehealth, a licensee must establish written protocols that address: (a) Authentication and authorization of users; (b) Authentication of the patient during the initial intake; (c) Authentication of the origin of information; (d) The prevention of unauthorized access to the system or information; (e) System security, including the integrity of information that is collected, program integrity, and system integrity; (f) Maintenance of documentation about system and information usage; (g) Information storage, maintenance, and transmission; and (h) Synchronization and verification of patient profile data. Suggestion: The consultant that provides the secure asynchronous store-and-forward technology can provide these policies.

    COVID-19: This is not a Medicare requirement, but it is a requirement under New Jersey and it has not been waived.

11. **Privacy Policy**: If a licensee communicates with patients by electronic communications, other than telephone or facsimile, then the licensee shall have written privacy practices that are consistent with HIPAA standards under 45 CFR 160 and 164 to protect individually identifiable health information. Such privacy practices must include (a) privacy and security measures that assure confidentiality of patient identifiable information and (b) transmissions, including patient email, prescriptions, and laboratory results must be password protected, encrypted electronic prescriptions, or protected through substantially equivalent authentication techniques. The licensee must provide a patient, before the Appointment, with copies of the written privacy practices and the patient must acknowledge, in writing, the receipt of the policy. Suggestion: The consultant that provides the secure asynchronous store-and-forward technology can provide these policies or the information needed to adjust the licensee's current policies. Also, have the patient sign the privacy policies.

COVID-19: Medicare and New Jersey relaxed the video requirement such that a licensee can use non-public facing platforms. See No. 6.

12. **Telemedicine Exclusions:** A licensee's use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission is not considered Telemedicine. However, you have to be concerned with HIPAA issues when using emails, instant messaging, etc.

    COVID-19: See No. 6 with regard to audio-only technology.

13. **Exceptions to a Licensee-Provider Relationship:** A licensee does not need to have an established licensee-provider relationship under the following four circumstances:

    a. During informal consultations performed by a health care provider outside the context of a contractual relationship or on an irregular or infrequent basis, without the expectation or exchange of direct or indirect compensation, or informal consultations with another health care provider performed by a licensee outside the context of a contractual relationship, without the expectation or exchange of direct or indirect compensation;

    b. Episodic consultations by a specialist located in another jurisdiction who provides consultation services, upon request, to a licensee in this State;

    c. A licensee furnishes assistance in response to an emergency or disaster, provided that there is no charge for the assistance;

    d. A substitute licensee, who is acting on behalf of an absent licensee in the same specialty, provides health care services on an on-call or cross-coverage basis, provided that the absent licensee has designated the substitute licensee as an on-call licensee or cross-coverage service provider.

Other COVID-19 Changes

I. MEDICARE:

A. Location of Licensee: Licensees can now furnish telemedicine services from their own home as opposed to their office. In addition, the licensee is not required to update their Medicare enrollment with the home location, but the licensee should list the home address on the claim to identify where the services were rendered. According to CMS, the discrepancy between the practice location in the Medicare enrollment and the practice location identified on the claim (provider's home location) will not be an issue for claims payment.

B. Location of Patient: Medicare had strict rules on where a patient had to be located to qualify for telemedicine. Generally, those locations are limited to a clinical site of service, such as a physician office, critical access hospital (CAH), hospital, SNF, or community mental health center. In addition, the patient had to be located in a certain

geographic areas, such as a health professional shortage area within a rural census track. CMS has waived all of these limitations, therefore, allowing licensees to furnish services to patients that are in their homes or other locations and anywhere in the country.

C. Licensing Requirement: A licensee no longer is required to hold licenses in the State in which they provide services if the following four conditions are met: (1) The licensee is enrolled in Medicare; (2) The licensee must possess a valid license to practice in the State that relates to his or her Medicare enrollment; (3) The licensee – whether in person or via telehealth – is furnishing services in a State in which the emergency is occurring; and (4) The licensee is not affirmatively excluded from practice in the State or any other State that is part of the emergency area.

D. Beneficiary Cost-sharing: CMS issued guidance allowing licensees to reduce or waive cost-sharing for telemedicine regarding coinsurance and deductibles.

E. Frequency Limitations Removed: CMS removed the following frequency limitations: (1) Subsequent inpatient visits can be furnished without the limitation that the telehealth visit is once every three days; (2) Subsequent skilled nursing facility visit can be furnished without the limitation that the telehealth visit is once every 30 days; and (3) Critical care consult codes may be furnished to a Medicare beneficiary beyond the once per day limitation. For the specific codes, please click CMS Flexibilities.

F. End Stage Renal Disease (ESRD) Services: Licensees no longer must have one in-person visit per month for the current required clinical examination of the vascular access site. CMS is also exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: Individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.

G. Nursing Home Residents: CMS waived the requirement in 42 CFR 483.30 for licensees to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth.

H. NCD and LCD: To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.

II. NEW JERSEY

A. Location of Licensee: New Jersey statutes and regulations did not prevent a licensee from conducting telemedicine from his or her home so no changes were necessary. Any Medicaid restrictions, however, were removed so that licensees can provide telemedicine services from any location, including his or her home.

B. Location of Patient: New Jersey statutes and regulations only apply to New Jersey residents so no changes were necessary. Any Medicaid restrictions, however, were

removed so that patients can receive telemedicine services from any location, including his or her home.

C. Licensing Requirements: Although Medicare has loosened this requirement, a licensee must still comply with the law of the State where the patient is located. Thus, if a New Jersey licensee, who is not licensed in Pennsylvania, seeks to treat a patient located in Pennsylvania, then the licensee must determine whether Pennsylvania has removed the requirement that the licensee must be licensed in Pennsylvania to conduct telemedicine with a patient located in Pennsylvania. The law of each State is different and, although many States have removed the licensure requirement due to COVID-19, these states have imposed other and different conditions.

D. Beneficiary Cost-sharing: Private insurers are required to cover these services without any cost sharing, i.e deductibles and coinsurance.

E. Frequency Limitations Removed, ERSD and Nursing Homes: New Jersey has not issued a blanket waiver, but to the extent a patient receiving these services has private insurance, the licensee should contact or view the websites of private insurers to determine what they are waiving.

COVID-19 Billing Changes

All licensees should consult with their billing contractors, but below is some general guidance

III. MEDICARE:

A. There are three types of Medicare Telehealth Services:

Expanded Services: CMS added over 80 new CPT Codes for telemedicine services as a result of COVID-19, which, according to the guidance, titled CMS Flexibilities, can be provided to new or established patients. These CPT Codes are paid as if the visits were in-person.

Virtual Check In Codes (G2010 and G2012): These services existed before COVID-19 and initially applied to established relationships only, but CMS has recently waived the established relationship requirement. Besides physicians and qualified practitioners, CMS expanded the practitioners that can engage in Virtual Check Ins to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.

Virtual E-Visit Codes (99421-23 and G2061-2063): These services existed before COVID-19 and initially applied to established relationships only, but CMS has recently waived the established relationship requirement, and confirmed as such in a letter to clinicians. Besides physicians and qualified practitioners, CMS expanded the practitioners that can engage in Virtual Check Ins to include licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists.

B. Audio-Only Visits: CMS will reimburse for audio-only telephone E/M visits using CPT codes 99441-99443 and 98966-98968. These codes were not previously reimbursed by Medicare, but are covered for the duration of the public health emergency to reimburse for cases where the two-way, audio and video technology required to furnish a Medicare telehealth service is unavailable. Even though these codes require a prior relationship, CMS has waived that requirement. In addition, CMS extended the services to other providers to include licensed clinical social worker, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists.

C. Place of Service: CMS has instructed physicians and practitioners, through a recent interim rule, to report the Place of Service code for telemedicine services as if the services had been furnished in-person. This will allow CMS' systems to make appropriate payment for services at the same rate as if the services were furnished in-person. For example, a physician practicing in an office setting who sees patients via telehealth, instead of in person, would report POS-11-Office. CMS has also instructed practitioners to use telehealth modifier, modifier 95, which should be applied to claim lines that describe services furnished via telehealth.

Before COVID-19, billing guidance instructed providers to use the POS-02-Telehealth code to indicate the billed service was furnished as a telehealth service from a distant site. Telehealth services identified using POS-02 are paid at the physician fee schedule facility rate, which is lower than the in-person rate. CMS noted in its interim rule that practices may continue to use POS-02-Telehealth "should [they] choose, for whatever reason," but will be paid using the lower facility payment rate if they do.

We strongly urge you to consult with your billing contractor regarding this issue.

D. Reporting of E/M Visit Level: CMS will permit, pursuant to its interim rules, reporting of telehealth E/M office or other outpatient visits based on either (1) time, which is defined as all of the time associated with the E/M on the day of the encounter; or (2) Medical Decision Making (MDM). CMS is not requiring history or exam to be used in selecting an E/M service via telehealth.

E. Remote Patient Monitoring: Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient's oxygen saturation levels using pulse oximetry. For the specific codes, please click CMS Flexibilities.

F. Workforce Revisions: For services requiring direct supervision by a physician or other licensee, that supervision can be provided virtually using real-time audio/video technology.

IV. NEW JERSEY:

A. Department of Banking and Insurance issued the following guidance requiring insurers and commercial HMOs to:

Pay in-network health professionals at least the same rate for telemedicine services as for in-person services, including but not limited to covered mental health and behavioral services, physical therapy, occupational therapy, and speech therapy.

Grant any requested in-plan exception for individuals to access out-of-network telemedicine services when an in-network telehealth provider is not available.

Cover telemedicine services using any platform permitted by state law. Carriers are not permitted to impose any specific requirements on the technologies used to deliver telemedicine and/or telehealth services (including any limitations on audio-only or live video technologies) during the COVID-19 emergency.

Not require more documentation for telemedicine services than they require for in-person services.

Cover these services without costs sharing (i.e. copayments, deductibles, or coinsurance).

Not impose any restriction on the reimbursement for telehealth or telemedicine that requires that the provider who is delivering the services be licensed in a particular state, so long as the provider is in compliance with P.L. 2020, c.3 and c.4 and DOBI's emergency guidance.

Not impose prior authorization requirements on medically-necessary treatment that is delivered via telemedicine or telehealth.

B. New Jersey Medicaid: According to a newsletter in March 2020, licensees may bill for any Medicaid billable service using the same billing codes and rates used for face-to-face services. There is no need to use any additional procedure codes or additional modifiers. Any face-to-face requirements or site specific locations under the Medicaid Program have been waived.