Expanding Telehealth Services During Covid -19

Healthcare Industry Group

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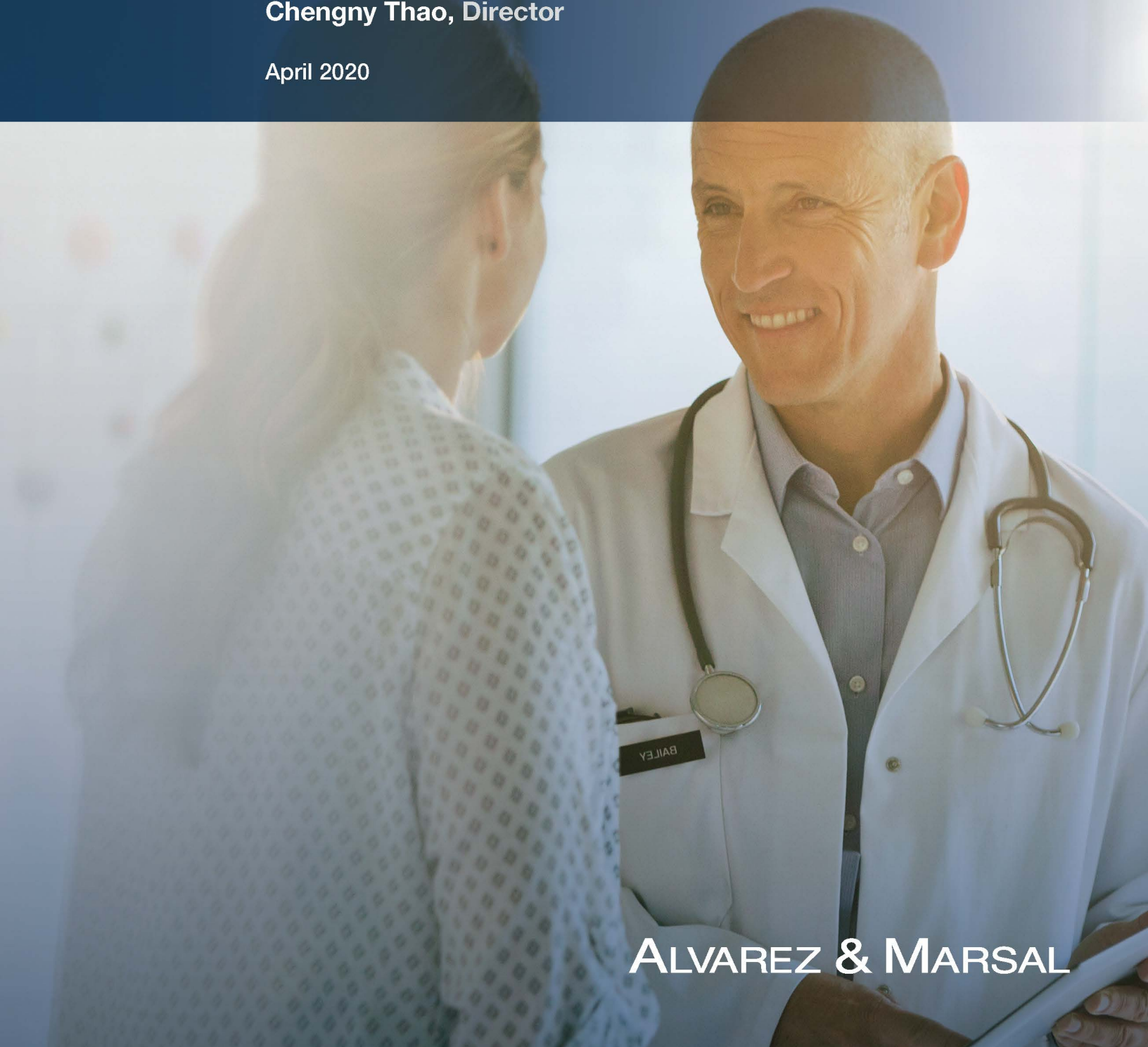

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ABSTRACT

Telehealth encompasses the technologies and tactics to deliver virtual medical, health, and education services. With the COVID-19 pandemic, Medicare and other payors have significantly eased service and billing restrictions on telehealth; posing an opportunity for organizations to supplement or enhance reimbursement revenue during this time of emergency. Recent changes in regulations have extended coverage and reimbursement for telehealth into other areas such home health, psychiatry, physical therapy, occupational therapy and speech language pathology. It is highly possible that implementing a strong telehealth foundation will not only assist in short term viability during this crisis, but also pave the way for a vastly altered care delivery landscape moving forward.

Key Points:

1. Telehealth is an appropriate approach to address the needs of the patient and healthcare organization related to COVID-19.
2. Federal and state agencies have relaxed and expanded laws and regulations surrounding the delivery and reimbursement of telehealth. However increased audit and review of telemedicine services will be likely once the current crisis ends.
3. Documentation will be a critical step to ensuring long-term viability of any/all telemedicine offering.
4. In consideration of expanding telehealth into an organization, providers should consider the legal, regulatory and contracting elements prior to implementing operational workflows within clinical operations and revenue cycle.

INTRODUCTION

In response to COVID-19, federal and state regulations have quickly evolved to expand telehealth access to Medicare and Medicaid beneficiaries. Commercial insurers are taking a varied approach to expand telehealth coverage during this time of crisis and beyond. Providers with existing telehealth capabilities are working diligently to increase the volume of patients they can serve, while new providers are quickly entering the market. Providers that have historically operated outside of telehealth have a tremendous opportunity to provide virtual care to their patients in a safe and socially responsible environment.

This article summarizes significant changes in the telehealth space and provides recommendations on how a practice or healthcare providers can expand telehealth during the COVID-19 pandemic. Our A&M team is closely monitoring the regulatory changes while partnering with our clients to implement telehealth services. We are available to answer questions arising from any of these developments.

The article is arranged into four sections:

I. Regulatory Updates Expanding Coverage for Telehealth Services
II. Expanding Telehealth Services in Your Organization
III. Guidelines for Coding and Billing
IV. Payor Policies Regarding Coverage for Telehealth Services

I. REGULATORY UPDATES EXPANDING COVERAGE FOR TELEHEALTH SERVICES

On March 6, 2020, Congress passed the Coronavirus Preparedness and Response Supplemental Appropriations Act (CPRSAA). As a result, physicians and other health care professionals can bill Medicare fee-for-service for patient care delivered through telehealth during the current public health emergency for COVID-19 and non-Covid-19 related services. Likewise, Medicaid and other payors have followed suit.

As of March 30, 2020, at the request of President Trump the Centers for Medicare & Medicaid Services (CMS) issued temporary regulatory waivers and new rules allowing for hospitals and health systems to deliver services at other locations. These flexibilities allow for practices to expand telehealth services to patients seeking care related to COVID-19 in addition to serving other non- COVID-19 related patient care.

Key Changes for Telehealth Services Include[1]

- For the duration of the COVID-19 public health emergency, Medicare will reimburse for telehealth services to patients in broader circumstances and can include psychiatry, physical therapy, occupational therapy, and speech language pathology.
- Telehealth visits will be reimbursed at the same rate as an in-person visit and include the flexibility for providers to evaluate beneficiaries who have audio phones only.
- The U.S. Department of Health and Human Services (HHS) has modified certain telehealth requirements such as waiving the originating site requirement for telehealth which permits the delivery of services to all locations including patients' homes.
- HHS will not enforce or audit for the established relationship rule, therefore allowing for treatment of established and new patients for the diagnosis and treatment of COVID-19 as well as conditions unrelated to the pandemic. A&M strongly recommends following standard practices during this time.
- Patients can be screened at alternate treatment and testing sites which are not subject to the Emergency Medical Labor and Treatment Act (EMTALA).
- Medicare coinsurance and deductible typically apply to telehealth services. However, HHS Office of Inspector General is providing flexibility for healthcare providers to reduce or waive cost-sharing.

The below table illustrates prior Medicare policies and current changes under COVID-19 as of April 2, 2020.

	Medicare Policy (Pre-CPRSAA)	Current Policy During COVID-19 (As of April 2, 2020)
Medicare Telehealth Visits (Applicable to private & commercial payors)	• Coverage and reimbursement provided for telehealth • Provider and patient must have a established relationship prior to telehealth services • Originating site must be designated in a rural area or limited to specific facilities and does not include patient home • Providers must utilize compliant and interactive video communication • Requires HIPAA compliant software • Documentation requirements are similar to in-person visit • Any healthcare provider eligible to bill Medicare can bill for telehealth services • Subject to state laws, includes: physicians, nurse practitioners, physician assistants, psychologists, social workers, nurse mid-wives, nurse anesthetists and other healthcare professionals	• No change – Coverage and reimbursement continues to expand to 80+ services • Established relationship is waived • Patient may be located in their home or any healthcare facility • Allows for the use of smartphones or laptop with a shared link to enable video. Providers also can evaluate beneficiaries who have audio phones only • Popular apps that allow for video chats including FaceTime, Facebook Messenger video chat, Google hangouts video, and Skype will be permitted; audio only devices are permitted also • No change for documentation standards • No change – Based on state laws these providers are eligible and can include: physicians, nurse practitioners, physician assistants, psychologists, social workers, nurse mid-wives, nurse anesthetists and other healthcare professionals
Licensing	• Providers rendering services must hold appropriate credentialing	• Note: states are waiving licensure requirements in response to COVID-19 allowing providers to practice across state lines. CMS has adopted and encouraged "credentialing by proxy" models that permit providers to streamline telehealth credentialing
Medicare Payments	• Payments made under Medicare Part B Physician Fee Schedule are at the facility rate • State pay parity laws determine if telehealth services can be reimbursed at the same rate as an in-person visit	• CMS will reimburse telehealth visits at the same rate and an in-person visit • CMS will now pay for more than 80 additional services when furnished via telehealth such as emergency department visits, initial nursing facility and discharge visits, and home visits
Out-of-Pocket Costs	• Deductible and coinsurance will apply	• CMS has encouraged providers to reduce or waive patient cost sharing • Office of Inspector General (OIG) will not be subjecting Providers to administrative sanctions for reducing or waiving any cost-sharing obligations
Other Billable Services	• Virtual check-in via phone (HCPCS G2012 and G2010) • E-visits or online patient portal communication (99421,99422, 99423, G2061, G2062, G2063)	• No change – virtual check-ins must be initiated by the beneficiary and require an established or existing relationship, it cannot be related to a medical visit within the previous 7 days or lead to a medical visit within the next 24 hours or soonest available appointment • No change – e-visits must be initiated by the beneficiary and require an established or existing relationship through a patient portal

Additional Medicare Coverage for Telehealth Services[2]

Additional Coverage for Services Provided as of March, 30 2020	
• Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285) • Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236) • Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238- 99239) • Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316) • Critical Care Services (CPT codes 99291-99292) • Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)	• Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347- 99350) • Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473;CPT codes 99475- 99476) • Initial and Continuing Intensive Care Services (CPT code 99477- 99478) • Care Planning for Patients with Cognitive Impairment (CPT code 99483) • Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139) • Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507) • Radiation Treatment Management Services (CPT codes 77427)
Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.	

Key Changes to Medicaid Plans for Telehealth Services

- CMS published guidance on the Medicaid State Plan Fee-for-Service Payments for Services Delivered Via Telehealth on March 12, 2020 encouraging states to utilize and cover telehealth services.
- States have broad flexibility to cover telehealth as no federal approval is needed for state Medicaid programs to reimburse providers for telehealth services in the same manner or at the same rate that states pay for in person services.
- If the State Medicaid program has managed care, telehealth reimbursement can vary from plan-to-plan.
- For Medicaid fee-for-service policies, information is on the Center for Connected Health Policies (CCHP) website. A State Plan Amendment would be necessary to accommodate any revisions to payment methodologies to account for telehealth costs.
- Coverage for telehealth services for Medicaid beneficiaries is still developing in each state.

Claims Submission and Payment Requirements

Medicare Administrative Contractor (MAC) have discretion to waive various requirements related to the claims submission process, including the timely claim filing window (e.g., one calendar year from the date of service), mandatory electronic claims filing, cost report submission deadlines, cost report desk review and audit activities.

For good cause, MACs may accept late claims denial appeal requests from providers, suppliers, or beneficiaries. In addition, to ensure appropriate cash flow, MACs may issue accelerated or advance payments to providers that are still rendering services or providers who are taking steps to be able to render services again – CMS may allow additional time to repay the accelerated or advance payment, if needed.

MACs may delay issuing tentative and final settlements to providers impacted by the state of emergency. Providers under an Extended Repayment Schedule may be able to defer monthly payments for a period of time. CMS or the HHS Secretary may waive interest on debts arising from a Medicare overpayment(s).

II. EXPANDING TELEHEALTH SERVICES IN YOUR ORGANIZATION

For medical practices looking to develop or expand telehealth services, A&M recommends the following:

Legal, Regulatory, Licensing and Managed Care Contracting

- Consult your legal counsel to ensure government regulations, state laws, liability and malpractice coverages have been appropriately reviewed prior to implementation.
- Be mindful of treating patient data –ensure privacy in all communications and enable encryption when possible.
- Develop a centralized repository to track providers' state licensures and states provider practices in. During the COVID-19 pandemic, CMS allows for out-of-state providers to practice across state lines, provided the provider is licensed in one state.
- Work collaboratively with your payor representative to review/arrange coverage of telehealth services and review payor guidelines on coding and billing; as these change frequently.

Telehealth Implementation Team

- Assemble a committee to expedite the implementation of telehealth services. The committee should be responsible for escalating issues, facilitating resolutions and making key decisions in alignment with legal, regulatory and managed care directives.
- Engage internal stakeholders to assist and support telehealth implementation. Stakeholders may consist of Compliance, Managed Care, Clinical Operations, Revenue Cycle, Coding, IT, Marketing and Physician leadership.

Information Technology

- Explore options to utilize telehealth functionality from your existing EHR vendor. If this is not an option, begin assessing which audio/visual communication platform will fit the needs of your organization for conducting telehealth services (e.g. Zoom, Google Hangouts Video); Identify and test audio phones as providers can evaluate beneficiaries who only have access audio phones.
- Develop an expedited process to report, track, escalate and resolve technology issues impacting the delivery of telehealth services.

Clinical Operations & Physician Leadership

- Identify acute patient populations to serve and establish visit criteria to appropriately triage patients
- Oversee the development and launch of telehealth training, documentation and coding for providers. Provider productivity will vary across your practice due to variables such as ability to conduct real time documentation and technological adeptness - these factors will drive the number of patients seen per hour. Leaders should continue to monitor performance, provide feedback and/or resources, and remove barriers impeding provider performance.

Scheduling

- Collaborate with practice and physician leadership to maximize scheduling. Identify which patients can be transitioned from an in-person visit to a telehealth visit. Notify impacted patients through an outbound call. Implement scripting for outbound patient calls informing patients their appointments have been transitioned to telehealth visits.
- To enhance the patient experience, develop a checklist of items requiring verification prior to the telehealth visit such as internet operability or insurance verification process. If specific telehealth access criteria is not met, reschedule the patient or confirm if phone only communication will suffice. Continue to utilize scheduling reports to monitor trends and identify improvement opportunities.

Documentation

- Documentation is critical to coding, billing and reimbursement for telehealth services. Given the emergency state, telehealth documentation guidelines remain the same as a face-to-face/in-person encounter. The information of the visit, history, review of systems, consultative notes and/or any information used to make a medical decision about the patient should be documented in the medical record.
- Best practices suggest that 1) documentation should include a statement that the service was provided through telehealth 2) location of participating patient and provider are noted 3) names and roles of any other persons participating in telehealth service are documented.
- In order to serve the growing number of patients in the most efficient manner, it is recommended providers complete documentation in real-time during the telehealth visit or shortly afterwards.

Coding and Billing

- See section *"III. Guidelines for Coding and Billing"*

Revenue Cycle

- Develop processes in partnership with the scheduling team to ensure patient demographics, insurance verification and cost sharing calculations have been noted in the practice management system prior to the telehealth visit.
- Develop reporting mechanisms to monitor and trend charges, payments and denials for telehealth services. Provide actionable feedback to respective areas or workflows contributing to nonpayment.

Marketing

- Engage the marketing team to launch press releases, develop signage and conduct updates to all internal/external media accounts. Begin gathering success stories for advertisement in local and/or online publications.
- Utilize text messaging notifications to current patients alerting them of telehealth option.

III. GUIDELINES FOR CODING AND BILLING

Place of Service (POS) and Modifier Usage (applicable to COVID-19 & non-COVID-19 services)

Per interim final rule issued on March 30, 2020 physicians and practitioners who bill for Medicare telehealth services should report the POS code that would have been reported had the service been furnished in person[3]. This change allows CMS to make appropriate payment for services furnished via Medicare telehealth which, if not for the COVID-19 pandemic, would have been furnished in person, at the same rate they would have been paid if the services were furnished in person.

- According to CMS, claims for covered telehealth services provided at the distant site should be submitted using the applicable CPT or HCPCS code. Using the POS code 11 or any code reflecting the location prior to COVID-19 indicates the services meet the telehealth requirement and will be paid at the non-facility rate if applicable.
- At this time, CMS has indicated modifier 95, synchronous telemedicine service rendered via real-time interactive audio and video telecommunications system should be appended. For telephone only services, CMS will allow CPT Codes 98966-98968 and 99441-99443[4]. It is advisable to follow local Medicare Administrative Contractor (MAC) guidance for final instructions on billing and documentation requirements for telehealth services.
- Medicaid guidelines for coding and billing will vary by state. Please refer to CCHP[5] for a state by state summary or visit your respective state Medicaid guidelines.

- Coverage, coding and billing guidelines will vary by payor. Please refer to your payor representative or their guidelines to ensure optimal reimbursement. Note: other payors may recognize POS 2 but do not require it for reporting telehealth services, instead requiring modifiers GT, GQ, GO or 95.

COVID-19 Telehealth Services

Effective April 1, 2020, billing laboratory tests for COVID-19 will encompass the following[6]:

HCPC	Usage
U0001-CDC 2019 Novel Coronavirus (2019-nCoV) Real-Time RT-PCR Diagnostic Panel	• This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2
U0002 – non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)	• This code is used specifically for Non-CDC testing laboratories to test patients for COVID-19

On March 13, 2020, AMA released CPT Category 1 Pathology Code for Coronavirus (SARS-CoV-2) (COVID-19):

CPT
87635 – Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) amplified probe technique

Please check with local payors to determine their specific reporting guidelines for this new CPT code. For additional COVID-19 coding direction please refer to the American Medical Association[7].

The table below summarizes Medicare billing and coding instructions.

Medicare				
Visit Type	**Place of Service**	**CPT/HCPC**	**Modality Examples**	**Modifier & Description**
Telehealth Visit (New or Established Patient)	• As of 3/30/20, CMS indicates telehealth services should report the POS code that would have been reported had the service been furnished in person prior to the emergency declaration. Options to Select: 11-Office 13-Asst. Living 17-Walk-in Retail 19-Off Campus OP Office 20-Urgent Care 22-On Campus OP Hospital 23-Emergency Room 31-SNF 32-Nursing Facility For a complete list, please see CMS.gov site	• 99201-99215 office visit • G0425-G0427 telehealth consult • G0406-G0408 follow up telehealth consults to patients in hospital or SNF	**Acceptable:** Facetime, Facebook Messenger Video Chat, Google Hangouts Video **HIPAA Compliant**: Skype for Business, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet **Telephone only will be accepted**	95 Synchronous telemedicine service rendered via real-time interactive audio and video communications
Virtual Check-In (Est. Patient Only)	• Not Applicable	• G2012 communication via virtual check-in and can be used via telephone • G2010 remote evaluation of recorded video/images submitted by established patient such as email	Telephone, video, text, email or Patient Portal Communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit with the next 24 hours	Modifier Not Applicable
E-Visit (Est. Patient Only)	• Not Applicable	• 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes • 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes • 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes • G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.	Telephone or Patient Portal (non-face-to-face)	Modifier Not Applicable

Non-COVID-19 Telehealth Services

With the passage of the CPRSSA and CMS expanding telehealth services, an opportunity exists to continue serving non-COVID-19 patients virtually. Additional services temporarily allowed to be performed via telehealth include care planning for patients with cognitive impairment, psychological and neuropsychological testing, physical therapy and occupational therapy and occupational therapy. These services can be provided to new or established patient visits minimizing disruption to the continuity of care. For a complete list of services please visit the CMS website.

Documentation, billing and coding for non-COVID-19 related services follow similar standards as an in-person visit and will paid at a similar in-person visit rate. POS and modifier requirements will vary by insurer. Medicare will follow the guidelines referenced earlier with a POS code 11 (or applicable location) in addition to appending the 95 modifier. Medicaid and other payors will vary by state. For example. UHC recognizes but does not require a POS code 02 for reporting telehealth services; modifiers GT, GQ, GO or 95 are required to identify telehealth services; phone calls (99441–99443, 98966–96968) online audio-visual E&M (99421–99423 and G2061–G2063), virtual check in (G2010, G2012) and remote monitoring are not considered telehealth services. Do not use POS 02 or modifier 95 with these.

This table summarizes the non-COVID-19 coding and billing guidelines for Medicaid and other payors.

Medicaid and Other Payors
Note: Usage of POS and Modifiers Will Vary by Payor Plan. Please check with Individual Plans

Visit Type	Place of Service	CPT/HCPC	Modality Examples	Modifier & Description	Modifier Usage
Telehealth Visit (New or Established Patient)	• Please see state Medicaid or payor plan guidelines as POS will vary	• 99201-99215 office visit • G0425-G0427 telehealth consult • G0406-G0408 follow up telehealth consults to patients in hospital or SNF	**Acceptable:** Facetime, Facebook Messenger Video Chat, Google Hangouts Video **HIPAA Compliant**: Skype for Business, Updox, Vsee, Zoom for Healthcare, Doxy.me, Google G Suite Hangouts Meet **Telephone only will be accepted**	95 synchronous telehealth service rendered via a real-time interactive audio and video telecommunications system	• Used to indicate telehealth services
Virtual Check-In (Est. Patient Only)	• Not Applicable	• G2012 communication via virtual check-in and can be used via telephone • G2010 remote evaluation of recorded video/images submitted by established patient such as email	Telephone, video, text, email or Patient Portal Communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit with the next 24 hours	GT Via interactive audio and video telecommunication systems GQ via asynchronous telecommunications system GO Services delivered under an outpatient occupational therapy plan of care	• Used to indicate telehealth services (except for demonstrations in AK and HI) • Reported when the service is performed as part the therapy plan of care by a qualified therapist
E-Visit (Est. Patient Only	• Not Applicable	• 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes • 99422: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11– 20 minutes • 99423: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes. • G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes • G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes • G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.	Telephone or Patient Portal (non-face-to -face)	GT via interactive audio and video telecommunication systems GQ via asynchronous telecommunications system GO services delivered under an outpatient occupational therapy plan of care	• Used to indicate telehealth services (except for demonstrations in AK and HI) • Reported when the service is performed as part the therapy plan of care by a qualified therapist

IV. PAYOR POLICIES REGARDING COVERAGE FOR TELEHEALTH SERVICES

Several health plans have announced support for telehealth services including offering telehealth services for free. Expanding availability will reduce risk exposure from the continued spread of COVID-19. Many payors have announced the waiver of cost sharing fees which include: Aetna, BlueCross BlueShield, Cigna, United Healthcare, Anthem, and Humana. Despite these announcements, beneficiaries should inquire with their insurer directly as coverage varies by plans. Additionally, Vice President Pence recently made an announcement indicating he has secured commitment from health plans to cover telehealth services. As of April 1, 2020, payor guidelines are as follows:

- **Aetna**: Waiving cost sharing for covered telemedicine visits regardless of diagnosis related or non-related to COVID-19 until June 4, 2020.[8]
- **BlueCross BlueShield**: Waiving cost sharing for telehealth services for next 90 days, effective March 20, 2020.[9]
- **Cigna**: Waiving out-of-pocket costs related to screening and assessing COVID-19, members may also receive virtual medical care not related to COVID-19 by physicians and certain providers with virtual care capabilities through May 31, 2020. Out-of-pocket costs may apply.[10]
- **United Healthcare**: Waiving member cost-sharing for treatment of COVID-19 through May 31, 2020 for fully-insured, Commercial, Medicare Advantage and Medicare plans. Beginning March 31, 2020 through June 18, 2020 United Healthcare will waive cost sharing for in-network non-COVID-19 telehealth visits.[11]
- **Anthem:** Effective 90 days from March 17, 2020: Anthem's affiliated health plans will waive member cost shares for telehealth visits, including visits for mental health and substance use disorders for fully-insured employer plans, individual plans, Medicare and Medicaid plans. Cost sharing will be waived for members using Anthem's authorized telemedicine service (LiveHealth online) as well as care received from other providers delivering virtual care through internet video and audio services. Self-insured plan sponsors may opt out of this program.[12,13]
- **Humana:** Effective March 10, 2020 for 90 days Humana will waive members out-of-pocket costs for telemedicine visits when participating with in-network providers for routine visits for primary and specialty care. Telehealth visits will be fully covered. Either video or phone visits will be covered for routine visits or specialty care visits.[14]

OUTLOOK

With the outbreak of COVID-19 it is critical to expand telehealth which will allow physicians and other healthcare professionals to coordinate care, minimize exposure and advance patients to the appropriate site of care. Given the recent lifting of restrictions on telehealth services for Medicare beneficiaries, it is likely Medicaid and other payors will follow suit, paving a path for long term opportunities.

At the direction of CMS, healthcare will see an increase in cancellations for all elective surgeries, non-essential medical, surgical and dental procedures which poses an opportunity for expansion of telehealth services. In coordination with Stakeholders, expansion of telehealth is achievable and accomplishes the following objectives:

- Re-directing patients to the appropriate site of care
- Supplements as revenue reimbursement during COVID-19 pandemic
- Serves as a convenience factor for patients and providers

Healthcare organizations are experienced in facing unique challenges, while managing the business of healthcare and striving to deliver the highest quality of care to patients. The COVID-19 outbreak has strengthened the necessity for expanding telehealth and has provided the forefront for providers to utilize telehealth to propel their organizations forward. A&M's Healthcare Industry Group professionals are equipped with significant experience and available to assist organizations in implementing custom telehealth strategies and solutions.

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With more than 20 years of experience in healthcare revenue cycle, IT, operations, and finance experience, Mr. Noonan has successfully implemented both revenue improvement and cost reduction initiatives for hospitals, physician networks, DME companies, toxicology labs, behavioral health providers, and other healthcare service providers nationally.

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With more than 33 years of experience managing all aspects of healthcare organizations. Ms. Rafferty's expertise spans across healthcare operations, finance, quality and compliance, productivity improvement and reorganization. She previously served as President of Women's and Infants Hospital, part of the Care New England Health System and Brown University, where she lead an operational turnaround in preparation of a merger. She also served as Care New England's Chief Compliance Officer.

Chengny Thao, Director, Healthcare Industry Group

With more than 20 years of experience in healthcare revenue cycle, clinical operations and process improvement. She specializes in healthcare revenue cycle operations. Her primary areas of concentration are healthcare strategy, clinical operations and revenue cycle improvement. Ms. Thao has been responsible for the assessment, development, implementation, and transition of revenue cycle performance enhancement solutions ranging from implementing centralized call centers, to reviewing A/R trends and improving back end collections.

CITATIONS

1. Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge." *cms.gov*, CMS, 30 Mar. 2020.
2. "Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19." *cms.gov*, CMS, 30 Mar. 2020.
3. Department of Health and Human Services Centers for Medicare & Medicaid Services. CMS, 2020, pp. 15, www.cms.gov/files/document/covid-final-ifc.pdf.
4. Moore, Kent. "Coronavirus (COVID-19): new telehealth rules and procedure codes for testing." *FPM*, FPM, 10 Mar. 2020, www.aafp.org/journals/fpm/blogs/gettingpaid/entry/coronavirus_testing_telehealth.html.
5. "State Telehealth Laws & Reimbursement Policies." *Center for Connected Health Policy*, Public Health Institute / Center for Connected Health Policy, 2019.
6. O'Reilly, Kevin B. "New CPT code for COVID-19 testing: What you should know." . , AMA, 16 Mar. 2020, www.ama-assn.org/delivering-care/public-health/new-cpt-code-covid-19-testing-what-you-should-know.
7. "Special coding advice during COVID-19 public health emergency." AMA, www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf.
8. "CVS Health announces COVID-19 resources for Aetna members." . , CVS Health, 6 Mar. 2020, www.cvshealth.com/newsroom/press-releases/cvs-health-announces-covid-19-resources-aetna-members.
9. Wicklund, Eric. "BCBS Network Waives Cost Sharing for Members' Telehealth Coverage." . , mHealth Intelligence, 20 Mar. 2020, mhealthintelligence.com/news/bcbs-network-waives-cost-sharing-for-members-telehealth-coverage.
10. "Coronavirus (COVID-19) Resource Center." . , Cigna, 1 Apr. 2020, www.cigna.com/individuals-families/health-wellness/topic-disaster-resource-center/coronavirus-public-resources#care-and-resources.
11. "Expanded access to care, support and resources." . , United Healthcare, 1 Apr. 2020, www.uhc.com/health-and-wellness/health-topics/covid-19.
12. "Information from Anthem for care Providers about COVID-19." . , Anthem Georgia Provider Communications, 1 Apr. 2020, providernews.anthem.com/georgia/article/information-from-anthem-for-care-providers-about-covid-19-4.
13. "Information from Anthem for care Providers about COVID-19." . , Anthem Colorado Provider Communications, 1 Apr. 2020, providernews.anthem.com/colorado/article/information-from-anthem-for-care-providers-about-covid-19-updated-march-20-2020.
14. "Coronavirus: Protecting members and reducing the spread of COVID-19." . , Humana, 1 Apr. 2020, www.humana.com/coronavirus/covid19-humana-member-resources.

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