On-Demand Webinar: "Additional Expansion of Medicare Telehealth Coverage During COVID-19 Pandemic"

Presenters: PYA Principals Martie Ross and Valerie Rock

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0:06
Good morning, everyone and welcome to today's webinar hosted by PYA additional expansion of Medicare Telehealth coverage during the COVID-19 pandemic.

0:19
If you a is a leading Professional Services firm providing expertise and Healthcare text management consulting and audit and Assurance. We are pleased to offer you our thought leadership on this important topic.

0:35
All attendees have been placed in listen-only mode. You may submit written questions during The Question pane of the control panel. Our presenters will address as many questions as possible during the Q&A session at the end of the webinar if we cannot answer all questions due to time limitations, we will supplement the transcript to this webinar with are written responses. Please be aware with more people using online platforms outages.

1:05
Can occur should the webinar be paused we will work to restore it as quickly as possible and all of our webinars are recorded and released after the event with that. I would like to introduce our presenters Martie Ross and Valerie Rock.

1:26
Thank you, Laura. Good morning everyone. Thank you for joining us today. My name is Martie Ross. I'm a principal with the PYA strategy and integration group here in the Kansas City office. I'm joined by my colleague Valerie Rock a principal with our compliance Advisory Group in our Atlanta office.

1:48
And hopefully we can provide good content here regarding the Ever Changing rules that Is to be on Medicare Telehealth, so our agenda is to start talking specifically about Telehealth Services

first setting the stage by discussing the rules before the waiver took affect the application of the section 1135 waiver that significantly expanded Telehealth coverage during the public health emergency.

2:21
And now adding to these rules is the interim final rule that CMS published on Monday which made further clarifications and expansions we finish up with Telehealth will talk about virtual services and then finally moving on to the new coverage for Telehealth evaluation and Management Services, which was included in Monday's interim final rule will touch briefly on what we know about other payers coverage for Telehealth services and Valerie and I hope to leave sufficient time to address many of your questions, but is Lauren Noted will provide Witten responses to those that we are unable to address during the webinar itself. So please as we go through the presentation don't hesitate to type in questions on the question box on your screen. In fact, there's one right now already great time to starting with Telehealth Services before the 1135 waiver took effect on March 17 Medicare coverage for Telehealth.

3:34
Services was governed by section 1834 M of the Social Security Act that provision was added to the Social Security Act in 2001 and provided a very limited Telehealth benefit to Medicare beneficiaries.

3:51
But then if it was limited in so far as the statute imposed for restrictions on the availability of the service first, there's the geographic restriction that 1834M required that the patient reside in a rural area to be eligible to receive Telehealth Services. Secondly. There was a location limitation that the patient had to be physically present at a health care facility when the service was provided and associated with that was a facility fee that the location at which the present the patient was present was able to charge Medicare to cover the costs.

4:34
Of delivering that Telehealth service in addition to the professional’s charge at the Forefront performing the service at the distance site.

4:46
the third limitation imposed by 1834M is the service limitation that coverage for Telehealth Services is limited to a specific list of approved Services listed by CPT code and HCPCS codes and each year as part of the annual Medicare physician fee schedule CMS goes through a process of updating that list prior to the waiver that list said exactly what Hundred identified services that could be delivered via Telehealth if the service was not included on that list, there was no reimbursement under the Medicare physician fee schedule. If the service was delivered other than face-to-face, finally the fourth limitation imposed by the statute was the technology limitation that to deliver Telehealth services that are reimbursable by Medicare the provider must utilize.

5:45
The communications technology with both audio and video capabilities that permit real-time interactive communication between the provider and the patient and will discuss today. The modification CMS is made to this particular requirement that again, we're starting with a statutory requirement the statutory limitation.

6:08

So, what happens Overtime is CMS has begun to appreciate the value of Telehealth and a series of actions over the last 10 years. It has created exceptions to those various limitations that are in 1834 M such as providing coverage or Telehealth support through telestroke. So, hospitals are able to access telestroke services without regard to look without.

6:41
hard to geography also with respect to substance use disorders expanded services to allow that treatment to be delivered via Telehealth without regard to location or geography ESRD Services had a limit had an exception to provide services via Telehealth and Medicare Advantage plans were given broader leeway in those recent plan here to provide coverage for Telehealth services that The geographical location requirements but clearly for the last several years.

7:17
We've been going about this process incrementally in demonstrating the value of Telehealth and expansion and really our limitation on expanding Telehealth was congress's unwillingness to change section 1834 M in part because of the manner in which any change to that statute was board by the Congressional budget office rather than viewing Telehealth as a replacement for face-to-face services and offsetting the costs. CBO would always score those proposed changes as additional Services that's generating additional cost in the Medicare program.

8:02
however with the COVID-19 pandemic Congress saw fit to expand Telehealth coverage at least for the duration of the public health emergency and I'm March 6th as part of the coronavirus preparedness and response supplemental Appropriations act which we now all refer to as COVID 1A Congress expanded the secretary's Authority under Section 1135 to Two of the four limitations on Telehealth Services specifically the location requirement and the geography requirement. There is no Authority in the 1135 waiver supported by Congress to waive the services and Technology restrictions. So just by way of background is section 1135 waiver is again, it's referring to section 1135 of the Social Security Act.

9:01
It's the authority given to the Secretary of Health and Human Services to waive certain statutory and regulatory requirements in the case of a public health emergency and a declared National Emergency. And that's when President Trump declared the National Emergency on March 13th at then gave the secretary the authority to exercise the traditional 1135 waivers, but also this new way of Earth.

9:32
Already with respect to Telehealth Geographic and location restrictions.

9:38
So, since the March 17th Announcement by the secretary detailing the manner in which the waiver would be implemented. We've had a flurry of paper explaining the details of the talent the Nutella health benefit for Medicare beneficiaries, and we've cited those here on this page. These are also all linked on PYA’s COVID-19 hub.

10:08
part of our challenge is one has to read through all the documents and all these discussions of how coverage will apply how billing will work how services are to be coded to really have a full appreciation of the opportunity presented, but also to mindful of compliance risks associated with delivery of Telehealth services in these circumstances in addition to the CMS

documentation regarding way of re-implementation other agencies have weighed in within their jurisdiction.

10:49
So the opposite Inspector General has issued a statement with regard to beneficiary cost-sharing waivers the office of civil rights the agency within HHS that has jurisdiction for HIPAA has issued its notification of enforcement discretion, which we will discuss in Context of the technology used to deliver these services and then the drug enforcement agency has also issued Guidance with regard to the use of telemedicine in the prescription of Controlled Substances will also highlight that then last Friday and amazing to think it's only been a week last Friday Congress finally passed and the president signed the cares act which is the two trillion dollar relief bill.

11:38
Which included a number of Provisions relevant to Telehealth as well and will highlight those relevant provisions and then late Monday evening, I guess actually Tuesday Morning CMS published its interim final rule which included numerous Provisions relevant to the Telehealth benefit along with other significant relaxation of administrative requirements.

12:03
So, as we present today on the different components of In Telehealth Services, we will weave into this discussion those important changes made by the interim final rule. So that introduction I'm going to turn this over to Valerie to begin with a discussion of those providers eligible to deliver Telehealth services.

12:28
Thanks Martie.

12:30
So like Martie said we're going to walk through that interim final rule on the interweave that into our discussion today because there were some really significant changes but there's some things that stay the same. So, we want to make sure that we keep the barriers and the guard rails around what we're allowed to do. So historically the Physicians non-physician practitioners clinical psychologists licensed clinical social workers.

12:59
Dietitians nutritional professionals have been the eligible providers and that will stand as of today. So, as we talk through additional codes that are permitted and incident two Provisions that does not take away from the fact that those are the only providers that are allowed to Bill under the Telehealth provision.

13:23
So in line with that we had some incident two Provisions allowed within the interim final rule that that talk about and to Larry's nurses providing service direct with the patient where the physician is providing service via Telehealth and providing that supervision direct supervision now via incident to Via Telehealth service, so that things like a drug injection could be provided incident to as considered.

13:59

Supervision in that case so that allows direct supervision to be redefined. However, in that discussion within the interim final rule, it does not push over into the Professional Services piece.

14:15
So when we look at what is allowed for a nurse practitioner to do, you know, Ken the nurse practitioner Bill incident to a physician when in an office where it's so the physician and the nurse practitioner and the office together they're both providing Telehealth services to patients The Physician is available to that nurse practitioner to you know to be there in the incident to scenario, but could you billed that incident to for Telehealth and we believe that based on the language in the interim final rule stating that if a provider is providing, you know something that would have been considered a professional service.

14:59
Is the face via Telehealth with a patient that you would billed under that providers number? So, we recommend billing under the MPI of the rendering provider and in those Professional Service cases, and then under the cares act on the direct beam CMS did develop cell house payments for our HTS and FQHCs during the public health emergency for COVID-19. And so, what they're going to do is allow you.

15:29
You to bill for that Professional Service under the G zero seven one. They're going to take the average of other services the nine nine four, two one nine nine, four, two two and nine nine four, two three to come up with a payment for that service. So, you'll billed all your virtual communication Services Under that g 0 0 7 1 and that will allow you to bill new patients as well as establish patients.

16:00
Under that service and that you can gain consent from the patient real-time as the services being provided. So, it doesn't have to be provided prior to that. They can go ahead and change the next slide.

16:16
So, in the provision patients can be anywhere you're allowed to provide Telehealth for a patient anywhere in the country. So, one of the things again that is not going to change as the originating site B.

16:32
So, if you're providing service via a phone with video and audio technology, there would be no originating site the for that patient if you're not within that rural setting as originally planned. So, if you are an originating site that is allowed then you could still bill your originating site see, but otherwise, that would not be billed.

16:58
Another piece that was clarified recently and we've had several iterations of this over the past really week to 10 days is how do you billed for a provider that is in their home providing service to a patient that may be in their homes and what location do you actually billed?

17:20
And so, there was original information coming out that said that you had to credential the provider and they revised fat so now Do not have to enroll your home. If you're a physician

providing service from your home. You just have to indicate the home address on the claim. So, inbox 32 indicates the home and address in the on that claim. You'll use place of service based on where you would have otherwise provided that service.

17:48
So out of your office location, you would use places service 11 and then you'll use modifier 95 to indicate the Telehealth that it is a Telehealth service. That is a big change because we were using place the service O2 and that provided a facility rate when providing that service and now you'll be able to use place of service 11, which will give you that additional increase in Revenue there that appreciate the amount of cost on that. You're actually extending because you'll still have your nerve.

18:28
Soft and front desk staff Etc. coordinating the service next slide.

18:38
So, in the licensure area, there's been a lot of expansion in regard to licensure across state lines. You see that you could not provide those Services across state lines, but there has been a blanket waiver that did recently include the language that is there whether in person or via Telehealth, so now we have those permissions via Telehealth as well and then next slide.

19:08
Just make sure you're looking at your state guidelines. A lot of states have also brought down their walls and allow you to provide services across state lines. The thing that you'll want to note is that Physicians wherever you're providing service is where you will submit to the MACs in the Mac jurisdiction that you're within is how you will billed that service as opposed to where the patient is for those Professional Services.

19:36
next one so this is the list of additional services that have been added this week There's 80 additional codes that have been added to the Telehealth service list in addition to that your logic bill for new and established patients, even if those codes States specifically that therefore established patients and we'll talk about that even within the virtual visits as well note that the services do not require that they be related to COVID-19. You can provide these for any services that are medically necessary for that patient. And then also note that Therapy Services have been added to this list. So again, just because these Therapy Services have been added. It does not mean that there's an expansion on the eligible provider eligible provider list does not include pts. OTS or speech language.

20:38
Pathologist, so make sure that you're not including those providers as billable providers for Telehealth. The intent of this guidance is that the eligible providers would be able to bill these Services when they are providing them next slide.

20:59
So again, with the home visit versus office visit do you'll see that home visits were added to the list of allowed services. So, if you're providing a visit via Telehealth and the patient is at home, if you would have normally been providing that service in the office setting or in the provider-based setting you would still be billing the office visit codes.

21:22

If you would have normally been providing that service in the home, then you could use those homes as Codes as an option, but this is distinct from home health home health is also been given some additional Provisions, but these home visits would be the Professional Service. Not that not bundled into Home Health visits to make sure that those are distinct as well next slide.

21:53
This is the Nugget that has been provided in my mind the huge shift that then allowed within the interim final rule that gives a feeling that were getting closer to next phase. We can start talking about 20 21. I'm sure everybody's feeling like they're in the midst of March and April for a very long time. I'm sure you're glad to even get to April. So, we appreciate all of you on the front line.

22:23
That are dealing with this crisis, but here's a little bit of leeway that will allow us to be able to move forward at least for these office and outpatient in and visits the concept for 2021 and perhaps you're aware that the office visits office outpatient in am does it serve going to be following new guidance in 2021 in regards to how we document how we select the code?

22:50
So, the history and examination will I'll no longer be a part of the decision-making for the level of selection of the code will be using medical decision making or time and selection of the code but medical decision-making in 2021 is completely redefined and we don't have time to train on that.

23:08
So CMS has been kind and giving us this allowance and that for these codes and only these codes so do not include other E&M codes that you do not have to rely on the history and exam to select the Service for these codes the new patient established patient office visit that you can use the current guidelines for medical decision making or your typical inter-service time to select the service. So, the medical decision-making is based on your diagnosis your data reviewed and the risk to the patient.

23:46
So you would select a service based on that or you would select it based on the typical time and this This is different from our time definition currently which requires 50% of that time to be counseling and coordination of care that is stripped from the definition for this provision. So, in this case, you will just use the typical time to select your code at any given point next slide So within Controlled Substances Act, you're typically prohibited.

24:23
You prescribe a controlled substance in the absence of an in-person medical evaluations that the DEA is waived that and now allows if you provide prescriptions that provided prescription is issued for a legitimate purpose that you're using that audio-visual real-time two-way interactive communication and you act in accordance with federal and state laws. Then you can waive that requirement and provide that service via Telehealth.

24:53
with next line Again, the technology doesn't change we still have to use the real-time interactive audio-visual communication technology to provide Telehealth service. The OCR is relaxing its requirements for HIPAA that it will allow you in good faith to use any non-public remote communication products as listed here. They do encourage you to notify.

25:25
Your patience in regard to their privacy risk because there are additional risks for utilizing your phones for interactive services. But this is of course needed at this time next one.

25:43
Again, I mentioned before that you're going to use a different place of service. If you're in another facility area, you could use it in any area really? Whatever area that you are providing service and whether you're providing it in the office and the provider-based setting outpatient hospital inpatient setting in the Ed you would use the codes for that area in addition to the place of service for that.

26:13
Think area as well you do not you do not have to use place a service o to the places service o 2 provides that facility rate. So, you would be receiving less pay if you use that facility rate and your billing out of place of service 11. So, make sure you're using places service 11 or any other outpatient service code that would not be related to the facility payment because then you can get that increased.

26:43
Aunt because they're not using the place of service oh to you would use a 95 modifier. This is again a change from previous. They did not allow the 95 modifier in the past these the 95 modifier to indicate that this is a Telehealth service.

26:59
You also do not have to use the CR modifier that indicates that catastrophe disaster related service and there is a question out there in regard to whether Would be allowed to bill the facility fee in a provider-based service. So, at this point, we're not seeing any Clarity on whether you can bill that the g code that you would typically bill for an e/m and a hospital outpatient department is not on the Telehealth list. So, in order to billed for that, you would have to billed for any M. Which is also not allowed under the hospital outpatient Department billing. So, you're really kind of hamstrung in regard to that.

27:43
Even though the intent is to pay you fully for all of your expenses for that service. So, we hope to see some type of clarification on that in the future.

27:57
Then make sure that you submit the claims again to the Mac where your provider is serving the patient where the your provider is regardless of where the beneficiary is and the OIG is permitting the waiver of beneficiary cost sharing you do not have to collect if you find that the beneficiary is unable to pay next one.

28:26
So, to reiterate the we recommend that if you're billing NPP services that you billed direct under their provider number, there are permission for you to get a temporary enrollment under CMS. If you need to quickly and roll them, there are temporary enrollment and that is a fast process that you can add them to your roster by doing that make sure you limit the incident to billing to what is true.

28:55

Permitted at this point they speak to primarily ancillary services. And then the frequency limit for Telehealth has been removed for subsequent inpatient visits subsequent Nursing Facility visits and critical care Consultation Services. So that will certainly help those in the facility side. And then you are allowed to now provide Telehealth services.

29:25
Has for your typically Hands-On visit for your ESRD monthly capitated payments and the face-to-face visit with your Inpatient Rehab Facility patients as well as the face-to-face visit for the hospital recertification.

29:43
In addition, another allowance because I hope opioid epidemic is simultaneously occurring and may even increase during this time because of exclusion and our isolation right now that you are allowed to provide Telehealth Services via Audio Only in those cases where the patient does not have the audio visual capability next one.

30:12
I'll turn it back over to Martie to walk through the virtual services.

30:17
Thanks Valerie. Let's shift gears here and talk about what CMS has afforded providers Under the Umbrella of virtual services. And first, of course, it's to appreciate the distinction between Telehealth services and virtual services. And this is a construct that CMS has created in the last several years as it has developed.

30:47
embarrassment for communication technology Based Services that surfaces by their very nature involve a communication technology that there is not a comparable face to face service and CMS has interpreted Section 8 1834 M not to apply to Virtual services that it views the definition of Telehealth under 1834 m Only applying to those cases in which the communication tool replaces what would otherwise be a face-to-face service so over the last five years beginning back in 2015 with the introduction of Transitional Care Management CMS has been developing these rules up around virtual services and now especially in the interim final rule.

31:47
CMS is really super charging these opportunities to really fill the gaps that still remain even after the waiver and that as we will discuss the most significant Gap being that requirement of using both an audio-visual communication tool.

32:05
It's here in Virtual services that we find the opportunity for reimbursement for straight-up telephonic Communications next slide, please so let's start with this with virtual check-ins. This was a service that CMS first began reimbursing the beginning of last year.

32:27
So we have some guidance that is developed up through the annual Medicare physician fee schedule process as well as other guidance CMS has issued but this service is built under G 2012 accept rural health clinics and federally qualified health Centers bill for the service under go7 one you see here on the slide the CPT description for this particular service, but this is intended for all for compensating positions for time. They spend on the phone with patients answering questions that would otherwise generate an office business.

33:11
I always think about the mom and the middle of the night calling with the with the kid's symptoms saying is this something I need to be worried about and before there was never a way for positions to capture reimbursement for that. But with the introduction of virtual check-ins CMS has created that opportunity guess my example wasn't very applicable since I was talking about kids and this is a and this is Medicare reimbursement, but that least gives you an example of the type of circumstance which is what its intended to fill that Gap. Clearly.

33:45
This is going to be Relevant with COVID-19 is more patients have concerns and want to touch base with their positions. This is giving that opportunity for reimbursement CMS has been clear in its guidance that this can this is reimbursement for the time spent by a physician or a non-physician practitioner. This is not reimbursement for nurse called the reimbursement rate is very low. It says on the Medicare physician fee schedule roughly at $13 as you know that rate varies by location.

34:15
Location but that's roughly where that sits today for fee schedule reimbursement. The reimbursement for already seasoned FQHCs is going to vary now because of changing a mess has made to go7 one with talk about in just a second, but that rate will go up. Now VAR. HC is an FQHC in the interim final rule CMS made some important additions again to give us more flexibility in utilizing the virtual check-in codes first.

34:46
As Valerie referenced this extent expansion to both new and established patients, even though the official description of this code references established patients CMS will reimburse for virtual check-ins for new patients. Secondly CMS has applied the OIG's waiver of cost sharing to the virtual checkin as well initially CMS.

35:15
It's with regard to Virtual check-ins in early March continued to reference both the established patient requirement as well as the requirement to collect the beneficiary copay again, in the in the interim final Rule. Now, they're being clear on both points new patients are okay and you have the ability as a provider to waive cost-sharing now put an asterisk here. I had a question from a client earlier.

35:40
This week is worth noting that the fact that provider chooses to weigh the Okay does not mean that Medicare is going to pay a hundred percent of the costs Medicare will still only pay the 80% It's the providers decision not to pursue the 20% copay from the patient with the intention that this top become a barrier to patients pursuing virtual check-in Services CMS. Also qualify clarified in the in the IFR.

36:17
That the consent requirements still apply, and CMS has imposed this consent requirement with respect to most of the virtual services, but it has relaxed the requirement again in the public health emergency and it is allowing that you only need to obtain it. Annually that you can obtain the consent at the time the services being delivered.

36:39

So as you initiate the conversation with the patient, that's the opportunity for the practitioner to secure consent that As this is going to be the little charge and then also it gives you the option of having axillary staff acting under General supervision to in fact secure that consent in the document in the record. This is not a typical consent. I hear that word consent. I tend to think of a form where I have to sign my name here. It is simply documentation of a patient's oral consent in the medical record next slide, please.

37:16
Let's talk about eVisits. This was new reimbursement that CMS brought online this year. So, we have very little guidance around this particular opportunity, but it also is going to present new reimbursement. These are Eva's.

37:35
It's were intended to reimburse patient initiated communication that occurs via a HIPAA compliant platform such as a patient portal or through secure messaging so it's a cop I meant the telephonic communication that's reimbursed under the virtual check in code. This is using a HIPAA compliant platform such as a patient portal or secure messaging in the interim final rule CMS made the same clarifications with regard to eVisits as they did with regard to Virtual check in that it can be provided to new patients that you can weigh the copay or deductible.

38:16
And the rules regarding that securing of consent for this service as well appreciate that under the E visit codes. We have two sets of codes the first set our core Services furnished by physicians and non-physicians and you see there it is a time-based code. So, the time you spent interacting with the patient on the through the patient portal or gathering information to respond to the patient.

38:45
All of that is Cumulative we measured over a seven-day period you total that time and a bill the code appropriately based on time and you see you there the facility and non-facility rate of reimbursement. Those are the National payment rates for 2020 CMS also approved a set of combs to be utilized by non-physician Healthcare professionals. These codes operate in the same manner.

39:12
It is total time over a seven day period COVID-19 spent interacting with the patient or gathering information to communicate to the patient these codes at CMS notes in the interim final rule can be utilized by clinical social workers psychologists and then importantly therapists can utilize these codes this then becomes the vehicle the opportunity for therapists to secure some reimbursement for non face-to-face services that these codes By that first opportunity for them to accomplish that and so it will be important as we see you folks that are in need of those Services can at least have a Lifeline to continue communication with the therapists through the availability of the G20 61 through 68 3 codes next slide, please.

40:10
CMS in the interim final rule also made some important clarifications around remote patient monitoring. So, RPM codes came online for the most part last year as well January 1st of 2019. These are a set of four codes that fully reimbursed providers for engaging in remote patient monitoring. There is one code that reimburses for device setup and patient education. There is a which is billed one time.

40:40
/ upper an episode of care. Then there is a code that pays for data transmission.

40:47
So taking data from the device that is in with the patient and delivering that data to the provider so that they can review and analyze that data that is a monthly reimbursement available for the duration of the remote patient monitoring period and then we have two codes that are the position the Precision or non position practitioner codes what they do with the monitor data. These are very similar to The Chronic Care Management codes in that they are based on 20-minute increments of services across a 30-day period CMS has required that in the course of that period there be some live interactive communication with the patient or caregiver.

41:40
Her to ensure that that information is in fact involved in the patient's Continuing Care.

41:47
There are two codes here because there's an initial 20 minutes then a 20-minute add-on code so important clarifications that CMS made with regard to RPM for that are In the context of the public health emergency, but CMS made clear that in fact these clarifications apply beyond the end of the public health emergency the first being that you can provide the service for new or established patients the second being that the basis for performing the monitoring can be both an acute condition or a chronic condition that requires ongoing management that critical change at critical clarification.

42:30
Is that acute monitoring? This allows you to use remote patient monitoring for patients that are suspected to have COVID-19 patients that have been sent home from a facility yet still demand monitoring. This is providing in a vehicle to accomplish that again. The acute monitoring is not limited to COVID-19. But that is particular application here during the public health emergency also know that in the interim.

43:00
the final rule CMS also extended the rules with regard to consent as well as waiver of co-payment and deductible for the duration of the public health emergency for remote patient monitoring next slide, please Turn it back to Valerie. I'm to wrap us up on Telephone E&M Services then.

43:22
Thank you, Martie the next slide.

43:25
So when you look at these codes, these are telephone E&M codes that are differentiated by the type of Provider that would provide the service and they're very similar to that you visits that Medicare that Martie just walked through and that there you have that seven day prior versus 24 hours or cynicism available appointment restriction for if you provide an e/m, whether The face or via total visit then you cannot billed a service in addition to that. But Medicare is allowing us to bill for these telephone because it's now so the first three codes are for your physician and PPA or other qualified Healthcare Providers as defined by CMS. And then the last three codes are for those that are qualified non-physician Healthcare professionals.

44:18

And as Martie mentioned, this is expanded during This time so LCSW is clinical psychologists, physical therapists, occupational therapists, and speech language Pathologists are all allowed to bill these last three codes. So, this will give additional allowances for you to billed for these services and non-facility and facility rates have been provided again, even though these codes are defined as established patient codes.

44:48
You are allowed to use them for new patients and Just follow those similar guidelines to either visit's but that will give you some additional expansion. I'll just make sure if you are providing those Services as a therapist that you're utilizing your modifiers Geo GP or GN based on the type of service your provided next one.

45:16
And I'll turn it back over to Martie the wrap us up with other pairs. Okay, and it just briefly because we really want to leave time for questions, but just I read a couple of Articles this week and I'm sure you all have to about this expansion of Telehealth that applies to all payers. And in fact, that is not the case what we've discussed up to this point is only the expansion in traditional Medicare, of course Medicare Advantage plans are required to provide the same label level of coverage available.

45:45
To traditional Medicare beneficiaries and their Medicare Advantage plans, and thus Medicare Advantage should be paying for these codes Under the same rules as does medic traditional Medicare State Medicaid programs have historically okay store eclis being pre COVID-19 have been all over the map on what they pay for in Telehealth coverage and recent study said that in 2019 only four percent of Medicare beneficiaries.

46:15
Sure, he's had used in these sort of Telehealth benefits. So even if the bit was there it was not being widely utilized in the Medicaid space a great reference for State Medicaid policy is a center for connected Health policy. We have the link here. It's also available on our website that you can look to the particular state in which you intend to deliver the services the Trump Administration as part of the Telehealth labor announced strongly encouraging states to provide.

46:45
Tell health coverage within their Medicaid programs noting that there would be no need for federal approval.

46:52
The benefits were extended to the same extent as face-to-face services, but noting if the state were to be more restrictive, it would need to file a state plan Amendment again refer you here to the Center for Telehealth policy, which has been very diligent in updating changes by emergency order of State Governors on Telehealth expansion within Medicaid programs next slide, please And while we have some Source we can go to with respect to Medicaid coverage for Telehealth. There is truly no centralized source of data or information regarding current commercial coverage for Telehealth Services. Both States had Telehealth parity laws, but those parity laws, of course were limited to State regulated plans. Not a Riza plans and they also typically only reached coverage.

47:46

and not comparable reimbursement again resource here is the American telemedicine Association stated the state's report which goes through sort of those parity laws and detail there have been some states in the last several days that have actually taken action that have taken action to require State regulated plans to provide tell health coverage specifically, Massachusetts accomplish that bike The governor's order Minnesota ACT enacted legislation to that effect. So, there is some movement in this regard and certainly an opportunity for advocacy and your particular States, but we are seeing some plans voluntarily expanding emergency coverage.

48:31
It's as you probably realize it's a challenge to keep up with all the headlines of which program which plan is covering what services with what co-pays but we are seeing some voluntary expansion here to improve management of next slide finally just to wrap up and one more slide, please before we get to the questions. Just refer you to PYA's COVID-19 HUB where we keep both all of our webinar recordings and we've done a couple of webinars on the 1135 waivers. We did a webinar last week out that I was just Monday. We did a webinar Monday on the cares act all of those the actual recordings and the transcripts of the slides as well as our written follow-up Q&A.

49:19
Days are posted on that website as will be this webinar, hopefully by as well as our thought leadership articles and links to the important resources that we've identified. Those are all available on the on the PYA COVID-19 Hub. So, we have left ourselves 10 minutes to work through questions. So, I am pulling those up online now.

49:44
And we will just go back and forth between Valerie and me depending on who we believe is most qualified to answer the question. I'm Valerie. I am quite certain you get the first question. Well any of the services yeah.

49:57
Well any of these Services be payable when billed before if you're an originating site then then yes, but that goes back to the question that we have out in regard to if you're in a provider based setting or outpatient hospital settings. It does not seem like there will be facility payment for these Services because of the limitation of the e/m codes you may have permission within the Ed.

50:31
To billed because you're still using E&M codes, but that is not explicitly stated at this point.

50:41
Next question that we have a couple of questions regarding billing for physical therapy furnished via Telehealth as Valerie noted at the top. We still have the 1834 M restrictions on who is an eligible provider. It does not include any of the therapists apron eligible provider can bill for therapy.

51:02
That's what's permitted by the inclusion of those codes and the interim final rule, but as we discussed Is your opportunity as a physical therapist going to be in the virtual service codes in the E visits as well as the telephonic evaluation and Management Services. So, it is a thin line, but it is some line to keep connection with those patients as you're canceling in-person Therapy

Services. In fact, my sister just had hip surgery and she did a physical therapy Zoom visit and we even talked about how that could be appropriately billed. This isn't new.

51:39
Tell a telephonic E&M codes next one is can you talk about the modifiers GT GP and when they're appropriate to use there were existing programs that expanded Telehealth services in a unique manner such as the telestroke expansion as well as the use of store-and-forward technology in Alaska and Hawaii. I believe those expansions had particular codes attached to them.

52:09
If you are billing a service that would meet those prior restrictions. You would continue to use those codes is also question here about code 95, which is the code we used to use and then we didn't use now we're using again, I'm sure that was perfectly clear but a couple years ago CMS went away from 95 and instead directed the use of place of service o 2 and now since CMS wants to pay the non-facility rate can't use the O2 model. You can't use the places over so too.

52:39
So now we've gone back to listing the site at which the service would be delivered, but for the public health emergency and including modifier 95 again, one thing to clarify CMS and in the interim final rule said, we're not going to deny a claim that you submit with O2 and that's fine. But we're telling you if you want to get the non-facility rate, then you're going to need to use the place of service codes with the modifier 95 Valerie anything to add to that to make sure we're completely eyes.

53:09
Are you covered it?

53:14
I'm sorry, you can see how little these type word or you would appreciate this. Our certified diabetes educator is considered non-physician practitioners.

53:27
Valerie, I don't know. I think we could we could look into that registered dietitians nutrition professionals.

53:46
Are right so we'll follow up on that. Yeah.

53:59
Sorry, I do.

54:01
Can you restate the rules on incident to billing with appropriate supervision?

54:08
So direct supervision will now be allowed to be provided by a physician or non-physician practitioners meaning an NPR PA like a qualified healthcare provider via Telehealth.

54:26
So, the provider would be on the phone maybe at home or in an office and the patient would be perhaps in their home and A nurse would be dispatched to go and provide service to that patient

directly. And in order to cover the incident to requirements for procedures such as an injection. You could utilize Telehealth to cover that incident to requirement.

55:02
Another way you would say that Martie.

55:06
Now that's how I do it. Yep. Exactly. Okay, if a provider who is working from home originally worked in a provider based Clinic, would you Bill place of service 22 or 11?

55:20
As Bill place of service 22 it's where you would typically provide that service is how you would bill for that service. It's interesting because there's a to do onces in the interim final rule. There's the how do you determine place of service? And then there's also this discussion around how do you select the appropriate service? Because there are, I think that's highlighted in the fact that CMS included home visits.

55:49
In the expanded list of services for Telehealth, but when is it an office visit? And when would it be home a home visit and the advice there is we originally wrote These codes on the mm with the understanding that the content of service would bury based on the location. But because we're taking location out of the equation with Telehealth, then you want to select the code that most accurately describes the service so far patient is in their home.

56:19
Not going to beat the description of home visit but it is going to be consistent with the office visit. It's just but for the public health emergency, where would you have typically provided this service and what content of service most appropriately matches the code description so there's some room for creativity in there. I'm sure we'll certainly see some guidance coming out from CMS on that may have to go a few rounds with a couple of MACs that will die some claims, but you know, what would what's different?

56:49
Isn’t exactly on that. But if you have a patient on a skilled nursing stay and the provider does Telehealth Services. Can you bill the originating site in the rural health clinic or the are the distant site cost? And so, this is a this is part of those originating site rules if the facility and these rules have not changed and will not change. But if the patient is present at a facility that qualifies as an originating site, which is most helpful.

57:19
Care facilities and you're in a rural area. Then that facility has the opportunity to bill the originating site be think the last time I checked it was like $35 that I know it graduates up every year. There's a formula that CMS uses so I'm not certain what it's at today, but it is not it is not a significant be allowed.

57:46
If you have a patient that resides in another state must you pursue temporary State licensure, or does it depend on the other state’s rules.

57:56
So State Medical boards assume that they write the rules for the delivery of Health Care Services to anyone that's present in their borders CMS has separately required that is a condition of

payment you have to be Since then the state in which you deliver the service the section 1135 waiver takes care of the Medicare requirement. It does nothing with the state licensure rules Most states at this point have waived those licensure rules and would permit the delivery of Telehealth services from a provider in one state into their state, but they've done it in different ways.

58:36
For example, here in Kansas are bored of Healing Arts says you have to send a letter notifying the board of healing are Is that you're doing this, and it only includes Physicians they did not expand it to non-physician practitioners. So, this is sort of a buyer beware situation that if you're going to be delivering Services across state line that you again refer you to the Center for connected care. They are keeping excellent running tally of all of the orders that regard licensure issues. So unfortunately, I can't give you an across-the-board answer also. Unfortunately, we have reached the top of the hour.

59:12
So, we are out of our I'm we know there are lots of questions. We were not able to cover here but where we will work to post responses to the question. Again, the recording of the webinar plus the slides plus the transcript plus the QA will all be available on our COVID-19 website. You also have the contact information for Valerie and be available to answer this question. So, I will turn it back to you Laura to take us out.

59:42
Thanks Martie and thanks to both of our presenters Martie Ross and Valerie Rock. If you have questions, their presentation and contact information will be emailed to you along with a recording of today's webinar. Also, if PYA can provide assistance, please call or email us. You may also visit our website at PYAPC.com for more in details about our specific areas of expertise or just subscribe to receive PYA insights.

1:00:13
On behalf of PYA. Thank you for joining us and have a great rest of your day.

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