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

Presenters: PYA Principals Barry Mathis, Kathy Reep, Valerie Rock, and Martie Ross

Original Webinar Broadcast: March 26, 2020

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0:06
Good afternoon, everyone and welcome to today's webinar hosted by PYA getting online with Telehealth practical guidance for physician practices PYA is a leading Professional Services firm providing expertise in health care tax management consulting and audit and Assurance. We are pleased to offer you our thought leadership on this important topic.

0:33
All attendees have been placed in listen-only mode. You may submit written questions using 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 written responses. Please be aware with more people using online platform outages can occur.

1:13
With that I would like to introduce our presenters: Martie Ross, Valerie Rock, Barry Mathis, and Kathy Greenlee.

1:24
Thanks Laura. Hi, this is Martie Ross with PYA good afternoon everyone. Thank you for joining us this afternoon. It has been a busy week and we've done two webinars previously regarding the section 1135 webinars on Monday.

1:46
We did a deep dive into the requirements for the Telehealth waiver. A recording of that webinar along with the slides and a QA sheet are available on PYA's COVID-19 Hub or your reference as well as the materials from Wednesday's webinar where we went to the traditional section 1135 webinars. Today we're going to try and provide more practical guidance on how to stand up a Telehealth program in a relatively short period of time addressing technological considerations workflow

2:26

and process issues for your practices as well as how to engage your client your patients As you move forward with Telehealth just a couple of quick note follow up on what's happened this week since we first talked about the Telehealth waiver on Monday first, we had several questions regarding whether provide Telehealth services from your home if you have a practitioner who's working from home and can they provide The medical health services today CMS published a FAQ regarding provider enrollment and included in that epic there was a question on this issue CMS's response was that it is permissible that the providers home needs to be included in the enrollment information. Also the other significant development this week, of course is the Congress working on the CARES Act. That's the two trillion.

3:26
dollar COVID-19 Relief act. Included in there are three relevant Telehealth Provisions. First permitting rural health clinics and federally qualified Health Centers to bill for Telehealth services, and second permitting new patients to receive services versus via Telehealth, and third permitting providers to waive co-pays and deductibles associated with Telehealth on at 2nd and 3rd point

3:56
CMS guidance had indicated that they would not enforce those Provisions, but now we will have clear legislative directives. So just some updates on what's been going forward. But I want to do is you now to my colleague Barry Mathis, from his home office in Knoxville, Tennessee to address some of these technological considerations.

4:19
Thank you, Martie appreciate the introduction. If you want to reach any of the resources that we currently have out there the things that Martie had just described for use or the things that we're going to talk about during the webinar. You'll see there are some resources. I recommend you go out to the PYA Hub, we update that daily. It seems like or even hourly in some cases.

4:43
It's a fast-moving process that's going on right now and we are doing everything we can to keep up and the people following me. I promise you are the experts in this field. I'm the technology guy. I'm likely the only one that knows what a client server versus a cloud-based really means so I'm going to go over some of that information with you because I've been getting a ton of phone calls from providers hospitals, security folks ,compliance folks, even my family on what this whole Telehealth thing is and how they can get it and is it necessary these sort of things so it will advance. First thing

5:19
First. The number one question that I get since this all started was how quickly can I Implement some type of Telehealth solution and it really has come down to two or three different buckets the main two are in a conversation. It seems like they're really just wanting something to help triage patients coordinate patients. It's not a clinical visit. It's not a physician talking to a patient. It's not advisory in that state for those situations.

5:47
You are still fine to use Your telephone some of you are likely already doing that. However, you need to be aware that CPT code g 2 2012 if it comes to that virtual check into where there is some type of clinical provision in there, you're giving it a clinical advisory then it may be a virtual check in and to get paid for that. You have to follow those guidelines will be careful on

that clearly if it meets a face-to-face visit if it is something you're wanting to get paid for Medicare reimbursed for that and it falls within that Telehealth service.

6:19
as clearly defined by Medicare then that video has to be in there. It cannot just be a telephone call and that has been a source of confusion even for me as a techno guy. The people following me on this webinar had to clear me up on that. So I know what it feels like with everything that's going on there. So don't feel like you're left out if you just don't understand. We want to help in this seminar to get that to you.

6:48
So if you're using a personal device, this one is also come up just recently bury one of the things I'm because I'm a security guy. I'm concerned about my my staff security. We understand the relaxation of where we can provide these services and we have clinicians and even admin home staff at our office staff that are working from other locations, but they're calling our patients in the only thing they could use as their home phones.

7:12
We recommend that you use a mobile phone and use something like Doximity or any type of a Dialer. What these applications do it mask your phone number. It's the same type of technology and application that the guy going to sell you a new warranty on your Chevy calls and it looks like he's called in a right down the road the next neighborhood because it looks just like your phone number, low and behold it is not from your neighborhood. He's just masking. His phone number same thing. What you want to do is take that phone number from your office and mask your home phone with that.

7:44
So when you call that patient whether it's in a clinical setting, even a Skype setting or a FaceTime setting, you can use that number to mass that office so it looks like it's coming from the office it looks as though you're still operating out of the office one of the things that you may see is the patient again feels better. It doesn't look like it's coming from somebody's house. It looks more professional. It certainly goes to making the patient feel better about that visit. If you are in your facility by all means you're still going to use your telephone systems.

8:19
The next thing is several times this week I've had the conversation with physician providers clinics and even hospitals. Yes. There are a lot of relaxed things you can do around videoconferencing and still get paid in a face-to-face telemedicine situation or Telehealth situation.

8:37
The question is should you? Just because you can doesn't necessarily mean you should so some of the advice that I've been giving is there's a lot of systems out there that are HIPAA compliant, and GPR compliant, they are set up and they're very fast ramping those up and they're not tremendously expensive some even offering a lot of free trial situations. So all these in many of these in most cases can even be used after you've gotten through this to continue as your “go forward” telehealth strategy, which we'll talk about later in this webinar. So consider this before you run out and develop and just say let's start using FaceTime.

9:18

Start using Skype in certain situations. You don't have a choice. It's just put you against the wall. You've got to do it, we get that, but we would say sit back and look at your situation and say what are you going to do in the future? What process are you going to create? Would it be better to at least reach out to some of these folks and see if you can stand something up very quickly that also helps you down the road.

9:41
Now there are hundreds of Telehealth Solutions out there. I attend HIMSS, which is the health and Healthcare Information Management Systems Society. I attended over 22 or 23 of those and it seems like every year there's new Telehealth systems.

9:56
It's people coming up with startup companies, its existing companies coming up with something new, and there's just tons and tons to choose from so please do not take this slide as these are the absolute ones you need to choose. These are some that others have recommended. I vetted them out of it. I checked into that considering a few factors one. What's your population how difficult it is for those patients? Are they senior patients? Are they college students? You know who's likely going to be is it a cradle to grave? Is it a therapy system? It's you know, some type of physical therapy or psychological therapy, all these kind of things. What specifically is going on.

10:35
Is there a is there a Telehealth to help you in that versus just You'll Telehealth it's out there the first one you see there which was which was interesting to me and we have a client using this now many people remember back when CMS released the guidance around texting, you know, encrypted texting and hospitals one of the companies that emerged out of that. That was a very popular company was Tiger text.

11:00
Well tiger text actually has a Telehealth solution called tiger connect and if you are already using tiger checked, and I know a lot of Physicians Practices are, I would reach out to them and say how much did how much more difficult and costly would it be to simply add on the tiger connect and get the training online and get this started up likely one of the fastest things you can do. If you're already a tiger text client being a tiger connect client is not that far away. Okay, the vivify Health, it's very nice. It's included with a lot of caregiver visit specific two types of patients and intakes much like you would your EMR.

11:40
It is fairly inexpensive. It's not one of the cheapest that are out there. There are some free trials with that. It is very slick. Very professional and it boasts a very quick start up time. So, you know, maybe take a look that one if you're one of those therapies that I talked about and maybe you know the tiger connect or you know DocMD or WebMD something like that doesn't really meet your needs. There is one out there called Theranest it is it is really geared.

12:09
It towards therapy type institutions or therapy type clinics. So take a look at that. It is not terribly expensive again. Most of these that I have on here are somewhat affordable. Theranest is robust. I would say that Theranest does better than some, is it has a lot of Aftercare interoperability Connections with your EMR. Should you want to do that later VC one of the simplest Basics easy to start up that I've seen in a long time.

12:36

It boasts about a 10-minute from 10 minutes of contacting them. You can be seeing a patient that's their claim. So, you know multiply that a few factors but it is I went through the process myself. I took a look at it and it is it is something that if I had an aging population and if I was mostly geriatric care something like that and after care visits the sea is definitely one that I would look at. Doxy,me. It's kind of along with the next one there, which is MendMyFamily.

13:06
You just see it's me and there's MendMyFamily these two together these Are very if your Cradle to grave physician practices, Family Services, they have just a little bit of everything embedded with them. They're not that expensive the MendMyFamily, the one there and the on the bottom, right? They both that 99.85% connectivity ratio, which is which is very good because that's one of the things that you're going to be concerned about as you choose some type of telehealth. Is it reflects on your office?

13:36
It slows things down. It bogs up the system if you spend most of your time simply trying to stay connected. So pay attention to that when you are choosing your provider or your solution to this because it can make a big difference. These are just six that I've taken some time over the last couple of days and made some phone calls and went out looked at some reviews and this may be where you start you may go from here. You may already have your favorite. You may already be in one now and you're trying to figure out what's the best way to use it. Believe me the people coming from behind me are going to help you with that.

14:13
These next are ,after a conversation with a couple of small practices and single, they're like very I want to use it. But likely when this is over. I'm just not ready for a full-blown Telehealth strategy and I respect that certainly not trying to talk somebody into that. So these are six of them that I found out there that are really they're almost free and some cases. They actually are free you stand them up you use them and if you're not going to use any of the other services like home monitoring things.

14:43
Like that associated with their analytics, then you can use it as just your Telehealth visit information. It has the ability to collect documentation as long as you're not trying to create interoperability with your in practice dmr's and things like that. And these are likely some that would give you very quick stand up and almost no money and I would consider those for just that purpose.

15:09
So what happens tomorrow?

15:13
Right now, you know flattening the curve for the COVID-19, it's created this this necessity as will say to construct to strongly consider the Telehealth in your practice or in your clinic, but it really should be based on more and you'll hear me say that again and again, I wouldn't just jump into it simply because you can. As you're picking your Telehealth system ,and it doesn't take long to ask these questions the fact you can kind of cut and paste these and send them right to some of these vendors, but you should consider what Connectivity, does it work for the college student the same way that it works for my mother who 74 years old. Does it provide for apps? There's several Telehealth systems out there. They're very good. They're very

inexpensive. But you really have to go to a webpage. It's the only way to get it. That's just the way that they're written. They've not conformed or upgraded into some of the more modern what we call HTML5 coding ,which allows them to go from tablets to cell phones and apps and things like that.

16:12
So, Check that out as well. Does it provide integration you may at some point want to integrate in or somebody may want to integrate in with you to make it easier for you to transfer information back and forth that you have captured inside your Telehealth application. Does it integrate those EMRS, ask that question. Does it interact with in home monitoring some of those that I showed you on that first page those four six some of those have some very good in home monitoring peripherals that come with that so you can monitor the patient's through.

16:43
The telehealth, it is literally getting it right down to telemedicine and those virtual visits. Does it support multiple languages? This one came up two days ago Hey Barry, what'd Telehealth systems do any of them offer a quick note to launch out to an interpreter these sort of things and there are some that do and there are lots that don't there should be more of those it's sadly to say, but that's one of the questions if that's where your practice is if that's where your demographic is. You want to be consistent. You want to consider that before you start.

17:13
Art installing that sell health system or certainly paying for it and does it meet your state and your your federal your HIPAA, your ADA compliance requirements. Keep in mind that just because you meet the HIPAA doesn't necessarily mean you need your state you need to know that as well and then a lot of cases depending on what you're delivering. You may also have to meet the American Disabilities Act compliance.

17:36
So the landscape beyond 2020 this is what's fascinating to me and I went out and did some research and sharing this and I was even surprised I expected it to be a jump. I just had no idea it was going to be this big of a jump. Before the pandemic started wanting 10 patients according to a JD Power survey from 2019.

17:58
Were actually a consumer of Telehealth. Since this all started I contacted one very prominent Telehealth provider and said, you know, can you share, and they even posted this information as well, and they said 70% since the virus in, and they give me a different date. So when it get but will say since January 70% since the virus hit and then a hundred fifty eight percent Nationwide and then in Washington state, they saw it six hundred and fifty percent increase in their product.

18:30
So people are reaching out for the Telehealth there. And I think the fact that Telehealth is now cloud-based, you don't have to download software, virtually every one of those that I talked to you about just a minute ago. You don't have to download any software. You just have the app or you have you go to the website and everything's there. There's nothing a server you have to load or anything like that. It makes it very easy to stand up inside your practice.

18:56

Beyond 2020. It is said that the necessity of is the mother of invention and fewer events, you'll necessity more than a disaster. I wrote that last night, but it on the slide and I truly believe that if you look back in history, there's a lot of innovation that's coming because we had to do it.

19:11
We didn't have a choice and in you may be in that very case right now since the COVID-19 pandemic has come out those resources that likely you didn't know about are now top of mind for you and that's because you really in a have-to situation so it's likely that in this whole pandemic that's going on. There's a lot of first-time Telehealth consumers that are possibly going to get their first taste of this, and I know of one personally and the response was “I had no idea that you could do this.

19:45
I had no idea that you could talk to a physician and do this through the phone and then look at me” and oh, yeah, and this happened to be in a case where they already had a telehealth System, but I don't I think that's going to go away. Okay, I honestly believe that consumers like we do with many things that once we get a taste of it all of a sudden we want to be in the driver's seat. We start demanding of the manufacturers and the creators that look I have specific needs. Can you please create something for me? And that just has not existed in the Telehealth Community until this point.

20:22
So I'm excited about that, if there's a any type of positivity that can come out of something like this ,besides just bringing people together to work together, a technology technological jump in how we use Telehealth I predict is going to happen.

20:44
I'll share one thing with you. Then I'm going to turn this over to to Valerie my colleague. One of the examples that I have with as you consider your Telehealth product test those out. You don't have to get completely installed and in bed with this and then find out. Oh this doesn't work.

21:08
Well. Test those out specifically if you're going to use a a service that's now been allowed through the relaxation from CMS if you're going to use a skype for a Facebook or Google meet up likely some of you don't even know what Google Meetup is. So don't jump out to that if your patients like they don't know what it is. I myself called my mother and said hey Mom if I was your doctor right now, and I wanted to see you face-to-face you how to do that. The answer's no and I said, well just click the little camera on your phone and within just a few seconds. I was looking up my mother's nose and we could have had a conversation.

21:42
I could have instructed otherwise. But you know some of these Technologies are easier to use than other so I'll thank you for my time with you in this webinar. I'll hang around for questions, but I encourage you to think before you leap, but certainly if you leave pay attention to the regulations. Valerie?

22:01
Actually, Barry, this is Kathy, I'm going to take the next section if I can. Well, I'm sorry Kathy got my apologies. Kathy is next. My comments relate to your mother's nose, but a little bit more broadly. So I would like to spend a few minutes. I'd like to spend a few minutes talking about Telehealth from the experience of the patient and also do a commercial for what my colleague

Martie Ross talked about it the opening she and I did a webinar on Monday that went into the details of the new CMS.

22:31
Use Guidance with regard to Telehealth specifically talking about the elements of the waiver two items were weighed in response to this crisis. Both of those items really impact the patient and who providers can now reach and where they can reach patients. So that's what I would like to go through but this slide talks about before the waiver before the world changed so much what the general rule has been for Telehealth.

22:59
The general rule has been that the Patient has to be physically present at a health care facility to facility when they're providing or interacting with the provider through Telehealth and those facilities I have on the slide there called eligible origination sites and they're Healthcare facilities and keep in mind that the purpose historically no keep on this prior slide go back.

23:22
Matthew go back one slide, keep in mind that the purpose of this historically has been to allow people living in rural areas people in Medicare in rural areas to have access to professionals who are not in their Community. That's why you see this list of this particular mix of entities where the patient had to go.

23:40
So the patient could go say to the rural health clinic and they could have a Telehealth appointment with a specialist living in an urban area or in another rural community, but this really, Is requiring patients to travel even within their small towns or communities to one of these specific Healthcare facilities, and this is what's changed. Okay next slide.

24:05
So currently under the waiver that exist during the time of this crisis the rural requirement is waived so a doctor or provider can contact any Medicare patients anywhere that they live in an urban or rural setting they don't have to limit this just two people living in rural communities the other thing that's really significant is that the person on the other end the patient can have a Telehealth appointment from their home that Telehealth Services can be provided in all settings of care including the patients.

24:35
When you hear this described publicly, it will often be referred to as just this: a patient's home. But I wanted to point out that older people and people on Medicare live in all kinds of dwellings, not just living in single family units patients live in apartment buildings. A lot of older people live in assisted living or the independent apartments and a Continuous Care retirement community. A lot of low-income older people live in senior high rise.

25:04
Housing, HUD housing in those congregate settings. They have staff available. The may be able to help facilitate a Telehealth visit by assisting the patient and there will be some patients who need some help. Barry was able to accomplish this with his mother fairly quickly, but there may be some patients who need some help getting this setup and for people living in congregate settings, they kind of have ready-made people to call upon who can assist them.

25:30

That wouldn't have necessarily been the same opportunity before because these patients To go to a healthcare setting that we talked about in the prior slide next slide, please.

25:42
So I've been looking at, what's the latest information that I can find about the attitude of older adults with regard to using technology. And the most recent study I found was at the University of Michigan? They did a poll last fall on published this report on Telehealth and older adults and I think this is both helpful, but also has some warning signs.

26:04
First of all older people believe that the quality of an in-person visit is better than Telehealth 50% 58% of the people thought it would be better if you see the doctor in person, but nearly half of people were interested in having a Telehealth visit with their primary care provider, but there are some concerns people are worried that the provider will not be able to do a physical exam. You can see that on this.

26:27
They're worried that the quality of care won't be as good. Older people worried about privacy, they are concerned about how hard it is to use the technology. 47 percent said they're concerned about difficulty and also 39% are worried about seeing and hearing the provider. There are other surveys going way back for the past decade and what they all going to or these last two most significant factors. How easy is it to use it and how helpful will it be? So as you approach your patients about this new opportunity, I think it will be important to say why this is helpful to them why it's helpful to you and how they label how they'll be able to use the technology to connect. Will it be easy enough for them to do next slide?

27:13
I also think it's important to keep in mind that you shouldn't make assumptions about a patient's comfort with technology. Barry gave an example of his mother who is in her 70s. Mine is in her 80s, and we've been using FaceTime for a long time. So you can't even with a people in advanced ages assume that they're not comfortable. There are 8 million people on Medicare who are there because they're less than 65 and they have a disability.

27:37
They younger population may be more comfortable with technology, but the reason that That group of people's on Medicare is that they have a disability harkening back to various caution about making sure we're compliant with the Americans with Disabilities Act. It's also really important to not exclude family caregivers as we move to this Virtual Technology, whether it's a telephone or certainly a visit that's visual. Family caregivers are really important members of The Care team. These Technologies can support connecting the person on Medicare and a family member and actually may provide an opportunity.

28:11
now to Loop into the conversation family members who live at such a long distance that they're not normally in the conversation with they would like to be. And like I said earlier older people may need someone to help facilitate. This will be kind of a case-by-case basis, you know, 10% of people on Medicare are older than 85 half of people over 75 have a hearing loss. A lot of older people, millions of older people, have vision loss and cognitive impairments.

28:39

I didn't put numbers on those because the data Is on what specific impairment you're talking about? But there are many older people with cognitive impairment either disease like Alzheimer's or just old brains, just the cognitive decline that happens with Advanced age. And I have a background in the field of aging and can tell you that we can serve people and help them be independent in their home. So they have quite a few functional impairments and they can still live at home and some of them live alone. So don't assume that someone's not impaired just because you reach them at home.

29:10
They may actually be in trying to Make it work with quite a few challenges as they live independently. next slide.

29:17
Couple of things to think about before I turn this over. I just from my work with older people in my background. I think mobile phones are probably going to be the easiest way to connect. I think FaceTime has real promise. I understand everything Barry was talking about in terms of looking at your technology needs now and in the future, but I think mobile phones probably the easiest if someone needs facilitation, it may be someone who walk around the senior high rise with a tablet or laptop setup a place that the person could come.

29:47
For facilitation, I've spent a lot of time working with older people and talking about exploitation and Broad and financial exploitation. And we really encourage people not to accept calls from unidentified numbers.

30:00
Barry has pointed out that it would be helpful for the technology to reveal the doctor's office number. If you can't reach someone I would make sure they know what number you're calling from so that they don't assume your spam or someone unfamiliar. And finally if if you want to move to a position mission where because of that Telehealth technology, you will really ask that patients help do some of the monitoring at home. Keep in mind that some people still don't have phones, some people still have mine land lines, which is kind of amazing, but some people still have land lines. I have a colleague who does a lot of work with older people in their homes and last week. She said they're finding a lot of older people don't have thermometers. So that sort of basic monitoring with COVID-19 essential and you can't assume people have thermometers.

30:45
So if you're going to move to relying on people to look for symptoms or signs and relay those to you. You should ask a lot of questions about what they have available. And can they read it and see it if you're relying on them to do some monitoring home. So thanks for participating. I will turn this over now to Valerie. Thank you Kathy. So for the rest of the presentation

31:06
e're going to be talking about the compliance related to telemedicine related to coding and also virtual and Eva that but what you'll find is that there's going to to have to be some continuity in the process that we're deploying but then the physician practice so that you can actually work through the clinic flow. So that would probably start with the patient calling for medically necessary Chief complaint.

31:32

So they're calling they actually need service and then you're moving over to deciding whether that requires a patient consent that Medicare does not require a patient consent for telemedicine, but there are other Services and other states that require that patient consent so you don't want to automatically hope blanket assumption that that patient consent is not required. But you also may decide that you don't want to have a blanket assumption that it's going to always be required for your practice. So deciding how you want to deploy those forms and how you want to obtain that information is going to be important.

32:12
For example, the virtual visits require a verbal consent, which can be just Documented in the record. So there's different ways to obtain up consent. So you want to make sure you're following those guidelines and then the provider calls the patient if it's determined that service can actually be a telemedicine visit because that does need to be medically necessary and support standard of care for telemedicine visit.

32:39
So if that provider calls the patient conducts that visit and then documents all the service that was provided and obviously there's limitations to those service that can be provided. So within the EHR you typically have a list of documentation already in front of the provider. That's kind of a templated document that pulls out the full exam and a complete exam that would include palpation and other services that that would require the patient physically being present with the physician.

33:11
So you want to make sure that that documentation is removed from the from the Heard and not included. So the physician is going to have to take time to edit that record.

33:23
There's also options for transcription through some of the Telehealth service options that Barry mentioned and so if there is transcription performed during the service then you'd want to make sure that that is also included into your HER, whether that is stand into your EHR also reviewed by The Physician and signed by the physician so that can an be supported as a billable service.

33:50
Then you select the code based on the actual elements performed. And as I mentioned that the full exam is not going to be able to be performed to making sure that you limit the code based on the History exam and medical decision making that is actually provided in the medically necessary for that patient and then submitting the claim with the appropriate modifiers in place of service. Now modifiers and places service vary amongst on the type of service you're providing the state

34:19
you're providing that in, and then the payer that you're providing that under so the considerations that you want to think through for remote service will depend on the patient's presenting problems there Co conditions that create additional risk, if they're exposed to COVID-19 the patient's Insurance payer the state that provider is in as well as the state the patient is then if that's different.

34:44
So under the public health emergency were no longer limited to the patient being in a health professional shortage area so the patient may be at home or a clinic or hospital. These services

again have to be medically necessary and support the need for an audio-visual visit like Barry said just because we can do it doesn't mean necessarily that we should and if the service is not warranted in the manner that you can provide it over audio-visual, if there's some limitations that would not allow you to provide.

35:19
A standard of care that's required for the presenting problem, then you probably want to look for a different means for serving that patient.

35:29
Then another component I want to mention briefly is that the authorized distant site providers for Telehealth include Physicians, nurse practitioners, Physician's assistants, nurse midwives, clinical nurse specialist ,certified registered nurse anesthetist, clinical Just, clinical social workers ,registered dietitians, and nutrition professionals.

35:56
The Telehealth visits when provided in the home you would use the nine nine two one through nine. Nine two one five for those Services, even though you're there at the home you would not use the home Site Services you still have access to the G codes that are relevant to consultations.

36:17
If you have a consultant at a distant site and the patient, is at the originating site of emergency department or in Patient hospital setting or an assist setting you have these G codes to select from advancing to next slide.

36:37
And one thing to mention about Telehealth as you do have the ability to waive the cost the cost sharing for those services for the modifiers for Medicare Telehealth. You're not required to use the CR or Dr. Modifiers that have been submitted out.

36:57
You probably seen them on numerous occasions over the past week, but Medicare did send out another notice saying make sure you're not in In the DRC are on your Telehealth Services because they're not required the GT and 95 modifiers are also not required for Medicare. But many of the private payers are required for acquiring them, but you'll see is that when you're looking through your specific requirements for commercial payers that a lot of the information is coming out so rapidly and they're submitting out information. So rapidly that there's little consistency amongst the payers.

37:35
So what You may have to do for one within those modifiers. It's going to be different for another payer who you like me want to get a list together for each of the states that you serve for all the payers that you serve and making sure that those modifiers are accurate for each of those payers. The place of service is no different. The place of service O2 is used for Telehealth Services provided to Medicare beneficiaries, but that's not always the case for other payers.

38:05
So you want to make sure that youre providing the correct place of service for that payer and then there's been a recent release actually as of today where we've gotten clarification as as Martie said in regards to the location, if the physician is at home, than the physician needs to be

credentialed and you can contact your, actually call, your Medicare administrative contractor and immediately get that home location.

38:36
enrolled, so they're they're trying to make this as Swift as possible. Okay, Matthew, can you can advance?

38:45
So for the Medicare Telehealth is it we are allowed to to serve both new and established patients. There's still in the in the requirement. You'll see that there's a stablished patient requirements within the guidelines, but they are not planning to audit for that. And then we do anticipate that that will be completely allowed through the CARES Act the services that you might include our surgical follow-up routine reviews and six visits, but I'll reiterate again.

39:15
It's on the services that are provided need to be medically necessary and appropriate for the type of carrier providing if there's any elements of a certain service that require a face-to-face visit in the sense of physically face-to-face and I would not do those services in addition that a care still has their Telehealth was that you can reference on their website.

39:39
If a non-physician practitioner is providing the Telehealth service, make sure your billing under their own number. This is not something that you would be doing incident to if and PP is at their home and providing a service to someone at their homes and there would be no incident to you know, allowances they are so if the it's NPP is not credentialed there are temporary credentialing applications available. Now that are swiftly being approved so you can obtain that temporary credentialing application get that completed and then do a standard one in.

40:15
later date. So make sure you're documenting your history and your exam elements on any type of diagnosis that are being managed during that visit and making sure that code level is appropriate. So if you're being a new patient, you would expect that that code level because of the Lesser exam that you're able to do to be something in the neighborhood of 99201-99202 because of be very difficult to get a lot of exam elements within that.

40:48
Service. And then if you're utilizing telescribe, make sure there's actually some services that allow you to tell us Telehealth Services allow you to use a telescope to make sure that you're reviewing that documentation for accuracy and then have the physician or NPP find the record for that to be a supported service.

41:12
So in the next slide I wanted to show you this because this is specifically from West Virginia. Their documentation requirement and this gives you a sense of what people will be looking for when we're producing documentation in an audit. So this slide and the next slide includes some tips of what we would recommend that it be included like the identity and location of the patient.

41:42
Formation of the identity and qualifications of the physician the physical location and contact information is the physician The Physician patient relationship is established or new is the telemedicine technology that you're using appropriate for the patient's presentation. I would

actually document that clearly in the record and then if there is consent required that it's a if it's a verbal consent that that's documented in the record or if you obtained written consent.

42:09
I'll make a quick statement that was A change and then consistent was the service is consistent with traditional standards of care for the patient presentation and that the documentation justifies the course of treatment meaning tells the story on why you're actually treating the patient the way you are given the circumstances the next slide. So from Minnesota some additional documentation aspects of they've included is the time the service began in the time the service ended so supportive.

42:43
That that time amount will also help support that level of code and then the mode of transmission. Were you on Skype or you on FaceTime? We're using some other service. What service was that? The location of the originating site in distance light again, and then if you are obtaining a consultation through a distance i provider from a Hospital's perspective making sure that consult documentation is in the record move on to the next slide.

43:14
The next information is in regards to Virtual check-ins and Evisits and remember that these virtual check-ins and he's visits are not Telehealth and they do not have to follow the same guidelines as Telehealth. So when you're looking at these Services know that they're subject to copay and deductibles, but during the public health emergency. The fees can be waived.

43:42
The OIG just put out information that they're not going to put any AKs or Anti Kickback statute liability against the provider if you waive those fees. So they want to make sure that there's appropriate access to care and then the virtual check is can be via telephone or patient portal for example, and then the communication must be related to the medical visit within the past seven days and must not lead to the medical visit within the next 24 hours.

44:15
So it's a physician is speaking with the patient over the phone and decides to bring the And to the clinic to see the patient within the next 24 hours at the OR at the next available visit than they would not be billing for this service. The service is obviously based on time to make sure you're documenting the time as well. And then you'll want to document the verbal consent because of verbal consent is required to document that in the medical record. You do not have to obtain that verbal consent at every visit.

44:47
You just have to obtain it once for the year and then build the place of service for based on where the providers located. Next slide.

44:57
Joey visits are a communication with the patient using the patient portal or secure email for instance. The codes are based on time and capture the time spent for up to seven days because nine nine four two one through nine nine four two three can be billed by physicians Pas and NPS basically those providers that can build for EMS services. And then the G Codes allow for you, too.

45:26

Bill for those qualified non-physician healthcare providers that cannot build for EMS services such as physical therapists occupational therapists nutritionists and social workers and there are CPT codes for those visits that correspond to those Jesus G Codes as well to make sure that you know, which codes that those Pro that the payer requires. The CPT codes are nine eight nine seven zero through nine eight nine seven two.

45:56
next one So after we get beyond the storm will want to make sure that we're auditing to confirm that there was accuracy in the medical record. If there's any way that you can have some of the team's making sure that the Physicians are documenting appropriately early as they adopt this new technology monitoring for those to be accurate than that would be wise but I know you're moving fast and furious right now and may not be able to do that.

46:27
We are hoping that will have Type of leniency from the government for this time period from the documentation perspective, but we also know that there's Bad actors out there that have already been you know, taking advantage of our seniors and taking advantage of our patients. So they are going to be auditing. What I would recommend though is if you do have a 2020 audits that you basically demands that there's a stratification of the services during this.

46:59
Emergency period and Non-Emergency period because we do expect a higher sense or higher level of documentation errors during this time period and don't want that stratified across the entirety of 2020. So with that I will turn it back over to Martie.

47:21
Excellent. Thanks Valerie. Sorry, little user error trying to find the unmute button on the website here. First of all this to remind everyone that all registrants will receive an email tomorrow that will include a link to the recorded website as well as well as a link for you to access the slides.

47:44
We will then subsequently add the transcript for this webinar as well as our Written QA responses, but we're going to take the next 10 minutes here and work our way through the Q&A that we've received via the screenshots. I'll try and take a first swing at some of these but Valerie Kathy and Barry, please jump in with any qualifications or some additional thoughts.

48:14
First of all is a question about consent and the our attendee asks, how do we have consent form signed if we're providing Telehealth services for a new patient? Just to clarify the either the Telehealth Services nor the virtual Services require that the patient sign a consent form instead the virtual Services requires that the patient give oral consent, which is then documented in the record.

48:51
Now this does raise the question of how one shares required documentation with a new patient for the first communication is be a Telehealth today. In fact, the MS just published an MLN Matters email that addressed the question of sharing documentation in a hospital and it goes to providing those documents to an individual.

49:21

Neither has been diagnosed with COVID-19 or suspected to have COVID-19 team. But in that response, CMS highlighted that it may be possible to email documents to an appropriate address and that, extrapolating from that guidance from CMS, you are doing a new patient visit via Telehealth and be sure that you secure an address to which you can forward the required documentation.

49:51
such as, for example, the notice of privacy practices again that if you are going to take on new patients via Telehealth you sure that that is also a part of your process. Valerie anything to add on that from a coding that and documentation standpoint? I think that's the primary method that we've heard is email. Even we've heard actually where someone was just responding as approved. You know that they're approving.

50:21
That the that they agree to doing a Telehealth visit as consent just stating their approval versus a signature.

50:33
Great. Thank you. Martie, this is Kathy brother than me sitting here looking at my picture. Can we go back to the COVID-19 PYA slide? Yeah, Matthew we can go back up to that COVID-19 Hub slide.

51:03
Right after the agenda, that'd be great. Excellent. So next question.

51:08
We had asked for written Resources with regard to rural health clinic and federally qualified Health Center coverage for Telehealth now, unfortunately, we're in no man's land right now because the relevant provision is within the CARES Act that to point the two trillion dollar relief package that that passed the Senate last night. It is up for vote the house tomorrow, but just to provide background and context here Congress added the Telehealth benefit to Medicare back in 2001 via section 1834 M of the Social Security Act.

51:54
And in that it narrowly defined the benefit to include only Professional Services that are billed on the Medicare physician fee schedule. It also included the geographic and location restrictions. Well the focus here, it's limited to those practitioners the bill on the Medicare physician fee schedule.

52:17
So to this point there has not been a vehicle for a rural health clinic or an fqhc to receive reimbursement for Telehealth Services where the practitioner is present at an rhc or an FQHC, now today one workaround has been similar to how positions or non-physician practitioners that are based in rhcs or fqhcs provide services in an emergency department, or if you have a reassignment under common method 2 billing, that has also been a vehicle potentially capture this reimbursement.

53:04
That of course, is not the optimal way to provide this service. Unless Congress has included this provision in this pending legislation that directs the MS to create. Rhc and fqhc reimbursement

for Telehealth Services. Assuming that legislation is approved by the house tomorrow signed by the president still means we have to wait for CMS to do the work. It's assigned in that.

53:32
legislation and create a fee schedule codes to be billed and the like but most likely this is going to be retroactive back to the date on which the certain which the benefit was created. So we are likely to see you'll be able to bill for services being provided now, but we're going to pay really close attention to it and we'll have those resources available on the COVID-19 Hub is more.

54:02
Becomes available on Tuesday CMS administrator Cinema Burma participated in a CMS telephone conference. The question did come up about rhc fqhc coverage for Telehealth and she indicated they were well aware of the issue and working on it. So hopefully be a very quick turnaround on CH the care is act is approved.

54:26
next question concerned how do we identify whether there are Behavioral Health Services that are reimbursable as Telehealth and here will refer you to the COVID-19 hub The COVID-19 Hub which includes a link to the calendar year 2020 CMS approved Telehealth codes again referring back to section 18 34 M and the Social Security Act one of those requirements for Telehealth is that the service has to be approved by CMS as appropriate for reimbursement for Telehealth. So each year CMS publishes a list by CPT code HCSPCS Codes for 2020. There are exactly 100 identified Services several of which are Behavioral Health Services. So you'll need to go to that list identify the appropriate code.

55:26
Next question we had is when you submit claims for Telehealth Services, you include both E&M code and the Telehealth code clarify here again in reference to that list of Telehealth. Reimbursable Services. You will find there are specific E&M codes that sort of the full range of EMS EMS services are included on that list. There is no separate Telehealth code instead.

55:56
Bill with place of service o to CMS about three or four years ago replaced the modifiers in the Medicare program at least with instead billing for Telehealth Services designated by place of service o 2 in Valerie, you want to highlight the differences or commercial and Medicaid payers?

56:20
Yes, well it very nearly every by everyone but most of them are allowing the e/m service has to be built for the home setting and then you would just build that along with whatever modifiers they require some of them are requiring the CR along with the 95 modifier Etc. So it's primarily the animal services.

56:44
There's no additional code that you would build an addition to that there because Just billing for the Professional Service.

56:57
Great. Thank you Valerie. And in fact, this next question is right up your alley as well and documenting time is the time based on the time the position spends on the video phone with the patient or should it include the other time preparing for the visit in generating documentation.

57:15
Well, you might want to document both but I would document them distinctly because I think that there's potential that you could consider and I haven't seen this written anywhere but that you could consider this Telehealth Service as a face-to-face visit and therefore allowed to build based on time because it is a face-to-face visit because the intention of face-to-face is that you're interacting with the patient not just doing paperwork or Pairing for something or reviewing records and things like that. So I would document the face to face, you know, virtual virtually face-to-face visit uniquely, but Martie if you seen anything in regards to that, I have not seen it explicitly stated that it's going to be allowed that we can use time.

58:06
No, I have not now the virtual virtual check in code is 5 to 10 minutes the guidance on that includes both the time speaking with the patient in any immediate follow-up. That's how it was described in the 2019 schedule that no. I haven't seen it.

58:25
Otherwise Kathy and Barry you can argue over who gets to answer this one. Is there any guidance on how to provide interpreter Services when delivering Telehealth business?

58:41
Typically family members can serve as interpreters. Is there any relaxation on this requirement here?

58:49
This is Barry. I haven't seen anything to borrow a phrase from Valerie written down for that again, whatever whatever service that you're currently using as far as just a telephonic service. I do know some providers that are simply relying on that portion of it. So you may have a face-to-face conversation going in a Telehealth situation and and on the speaker or connected to that me.

59:19
Your be your normal telephonic interpreting service, but I haven't seen any specific guidance on that, but Kathy can weigh in if she has I can I can certainly do some research and follow up for you. No, thanks for leaving me. And I know I haven't.

59:35
Barry when you discuss these Technologies do some of them have the capability of creating a three-way conversation. Yeah, in fact a few of those that I mentioned on those six that was one of the kind of one of my requirements for those most of them have a way to create a three-way and some it's very like VC.

59:59
For example, it's very integrated into the product where it's if you want to identify Ahead of time via the phone number who may be a care provider is so if I'm a care provider for my mother I can already be in the system for that. So it kind of brings us up at the same time. Some of them are a little more rudimentary. So just like your face time you can always add a person into the conversation. So that's what you want to look out for they're all going to say they can do it. But what I would tell you is make the distinction between they can or it was actually baked into the design that makes it easy for you to do.

1:00:36

Thanks Barry. Unfortunately, there are a number of questions. We are not going to be able to address here in the webinar. But again, we will follow up with a written QA document. These have you can join us next Monday at 1:00 p.m. Eastern. We'll be doing our first webinar doing the Deep dive into the CARES Act particularly focused on the assistance being made available to hospitals and other providers as well as the small business administration.

1:01:05
Phones that are really going to be a bridge for many smaller position practices during this COVID-19 pandemic. Again. Thanks everyone for participating as you sign out. They'll be a small survey if you complete that. We really appreciate it. And otherwise have a great day.

1:01:27
Thanks to our presenters Martie Ross, Valerie Rock, Barry Mathis, and Kathy Greenlee. If you have any questions or presentation and contact information will be emailed to you along with a recording of today's webinar. So if PYA can provide assistance, please call or email us. You may also visit our website www.PYAPC.com for more details about our specific areas of expertise or to subscribe to PYA and site on behalf of PYA.

1:01:57
Say thank you for joining us and have a great rest of your day.