Kathy Wild:

Hello. My name is Kathy Wild and I would like to welcome you on behalf of the Quality Insights QPP Support Center Team to today's webinar to address how practitioners can help reduce the spread of the coronavirus by offering telehealth services to their patients. The title of today's webinar is "Operationalizing a COVID-19 Response Within the Private Practice: Innovating Practice Operations and Leveraging Technology". I'm going to take one minute to review a few housekeeping items before we begin the presentation.

Kathy Wild:

All participants entered today's webinar in a listen only mode. Should you have a question during today's presentation, please type it into the chat or Q&A box at the bottom right of your screen. We'll be discussing a complex topic, so we're going to compile a list of all of the questions asked today and provide answers in a question and answer document, which we'll provide to all registrants as well as post on our website by the end of this week.

Kathy Wild:

Today's webinar is being recorded. The recording along with the slide deck and the transcript of the webinar will be posted on the Quality Insights QPP Support Center website within the next few days. These resources can be found on the archived events page. We have posted a link to that webpage in the chat box.

Kathy Wild:

At this time, I would like to introduce our two presenters. Kem Tolliver holds dual bachelors of science degrees in healthcare administration and organizational management with certificates as a certified medical practice executive, certified professional coder and certified medical office manager. Ms. Tolliver has provided strategic and operational leadership to hospitals and independent practices for over 20 years. She is currently co-authoring the Medical Group Management Association's 2019 Revenue Cycle Management Handbook. Ms. Tolliver is President of Medical Revenue Cycle Specialists, which provides practice management and revenue cycle improvement, new practice start-up, payer contracting, medical coding, training, education and practice transformation efforts that include optimizing technology and leveraging innovative revenue cycle strategies.

Kathy Wild:

Our second presenter, Luigi Leblanc, is an electronic engineer and public health professional with over 14 years of experience in telemedicine and telecommunications technologies. He has served as the technical manager for many projects that require the collaborative efforts of healthcare providers, application developers and systems and engineers. Mr. Leblanc has led health information technology research initiatives that focused on patient self-management of their diabetes and hypertension through personalized web portals, combining social networking concepts, e-learning, online collaborative and electronic medical records and patient health records. He is a certified professional in health information technology and sits on various statewide advisory boards on MSOs and the health information exchange and he's also a commissioner for the Electronic Healthcare Network Accreditation

Commission. Mr. Leblanc has a bachelor's degree in electronic engineering technology from Hartford University and a master's degree in public health from the Howard University's College of Medicine. Mr. Leblanc possesses a two-tiered background as both an engineer and a public health professional. And now I would like to turn the presentation over to Mr. Leblanc to get us started.

Luigi Leblanc: *slide 2*

Thank you so much, Kathy for a wonderful introduction and I want to thank Quality Insights for putting on a timely webinar on a topic that I deeply and passionately care about, and we've been doing since 1996. It's almost bittersweet to see that at this time there's a sense of urgency and recognition that telehealth is a real utility that can benefit the public good. I do want to thank you all at the frontline as healthcare providers out there, the practitioners who've been asked overnight to respond to a public health epidemic and also to leverage this medium as a way to prevent unnecessary community spread and promote social distancing, but also to save lives.

The balance that you are trying to deal with, in your actual practice dealing with your chronically ill patients who may be elderly that you frequently need to see, monitor and engage with and your healthy patients who are coming in for well visits, while you're making space for the urgent and emergent cases that are relevant to this COVID-19 pandemic. So thank you all for this and for the time to share a little bit with you about telehealth the topic.

Luigi Leblanc: *slide 3*

Okay, so thank you. I am going to speak to you about getting started in telehealth, which is going to be the focus of my presentation. And next slide by way of disclosures, again, I represent a company called Zane Networks that focuses on telehealth consulting and health IT consulting in general and helping practices to implement the right technologies in their practice.

Luigi Leblanc: *slide 4*

So just to set the tone, next slide, in terms of what the definition of telemedicine is. I'm sure over the past week or two weeks or so you've heard a lot about telehealth and telemedicine and basically what it is, is the two-way real time interactive video and audio communication for purposes of evaluation, diagnosis and consultation, or treatment. So telehealth in its definition has been that you have to have a two-way audio and video, not just audio and not just video.

And that has been changed here with this new executive order. So there's some definitions in terms of what's considered an 'originating location' with a telehealth encounter and then there is the 'distant location' and that's where typically the remote provider or the specialist doing a telehealth visit would be. And so those are definitions called the originating site and the distant provider site.

And then there are modalities for delivering telehealth and typically they've been the telehealth visit, which is the interactive audio and video. You might have heard a word called remote patient monitoring, which is basically what now is being referred to as the 'virtual check-in', which allows you to do some things with regards to sending a store forward to the provider in real-time as if it's face to face. So we'll talk a bit about that as well. And then there's now of course the telephone only visits that have been allowed.

Luigi Leblanc: *slide 5*

Next slide please. So what thrusted this has been the COVID-19 pandemic and three actions that HHS has taken under the executive order from the president at what arises executive powers to really use this as a tool to literally save lives for patients during this growing pandemic.

And so on March 9th, there was the declaration in terms of leveraging telehealth and giving authority to expand telehealth, make it as flexible and as easily adaptable by clinicians and by patients. So that started the gears moving and then the president then further provided guidance and executive order to his agencies to remove the red tape, to remove the barriers that are presented in terms of licensure, in terms of credentialing, and the privacy and security barriers.

So all hands were on deck to make sure that this could be something that could be immediately utilized in order to help get some control and relief during these times. That happened on March 17th and then on the 22nd we started to see a lot of activities and fax sheets across all agencies to help clarify and provide some guidance and clarification in terms of what you should be doing and how to do it and how to implement the tool. Next slide please.

Luigi Leblanc: *slide 6*

So the exact authority that allows CMS to be able to take executive action around telehealth is the emergency, the national emergency authority, under the Social Security Act. It allows CMS to not exercise this 1115 waiver towards mitigation and action and leveraging this technology during this pandemic. It allows CMS to pay hospitals, to pay offices and others to furnish this visit and it dates back starting March 6th, 2020. So it broadens the definition and makes the agencies act on this.

And if you have been doing any kind of consultation services with a patient either by phone or other modalities, you can go back, as far back as March 6th of 2020, if you have recorded that, to bill for that service. It also addresses the eligible providers who can leverage this. And that's a real issue as we talk about shortage of providers. So they provided clarification and that guidance in terms of providers who can use telehealth services. And it also allows the Office of the Inspector General to remove a cost sharing or reduce the cost sharing burden that patients are often faced with when they see the provider. So now it removed that burden when you use telehealth during this time and by definition the provision is until such time that HHS were no longer in a declaration of national emergency. But during this time, there is no cost sharing and they can reduce the cost sharing burden on the patient. Next slide please.

Luigi Leblanc: *slide 7*

So the three telehealth services that we'll focus on today, which are germane to COVID-19 and responses around COVID-19, are the Medicare telehealth visit which basically is the conventional definition of telehealth, which is the audio and the video interaction between a patient and a provider as if they were face-to-face in an office setting.

The virtual check-in is allows a patient to initiate a call with the provider. It could be a telephone call, it could be a web-based call, it could also be flexible enough that you could send in a secure message or you could send in a video message of a lesion or something to the provider and then you get a response. So that's a quick check-in that you can do. And you can bill for that service prior to actually being

scheduled for an in-person visit or a telehealth visit. And then there's the e-visit which allows you to actually engage with the patient online through the patient portal. Next slide please

Luigi Leblanc: *slide 8*

So I want to talk about the Office for Civil Rights because everyone in the healthcare sector are all dealing with HIPAA privacy and protections. And so Office for Civil Rights is the enforcement authority as it relates to HIPAA. And what they have done under this, for this emergency here, is that they will not enforce and will not exercise the enforcement authority. They will waive any penalties for HIPAA violations against healthcare providers for serving patients in good faith during the COVID-19 public health emergency.

Specifically, you can use tools where you don't have a Business Associate Agreement with a vendor, such as Apple FaceTime, Facebook Messenger and video chat, Google Hangout, and Skype. Those are tools that come natively with a phone and don't necessarily provide you with a Business Associate Agreement. They want providers and frontline individuals to get started quickly so they said you can use those tools and if something happens that amounts to a breach, then we are not going to enforce it.

However, you should not use and cannot use Facebook Live and tools like Twitch and TikTok and other tools that are public facing social media tools that anyone can get access to and anyone can participate in. If you are doing something that has protected health information, it falls under HIPAA, and using such a public social tool would no longer be a two-way engagement or a three-way engagement between a patient, provider and an interpreter for the encounter. That falls outside of the protection of the waiver and the non-enforcement authority. Next slide please.

Luigi Leblanc: *slide* 9

So what it does say is it says that if you are selecting or if you're choosing what platform to use, CMS has a recommendation to also check with your state, because states have either expanded those recommendations or they've shortened the list of vendors that you may consider. You want to look at getting a tool that has a Business Associate Agreement or ask the vendor to provide you it, because that gives you that extra layer of protection. You don't have to worry about whether or not you fall outside of the parameters of the OCR. If you're looking at doing this, you will find that once you start to do telehealth with your patients, and your patients find it valuable, that you're going to want to continue it. So get a BAA with a vendor and look at what the BAA says before contracting. Next slide please.

Luigi Leblanc: *slide 10*

So the other piece that CMS has worked on, and I think this is great for telehealth providers and particularly when we're talking about a shortage or anticipated shortage of providers, is they have provided guidance and help to fast track the credentialing side of it so that you can get your providers onboarded really quickly so that they can provide telehealth services.

For practices that are bringing on new providers and those providers are not yet credentialed, there's a mechanism that you can exercise in the Section 1135 waiver to make sure that you get those providers going quickly so they can bill and get paid for the services. Next slide please.

Quality
Insights
Quality Payment Program Support Center

Luigi Leblanc: *slide 11*

So, consent, either verbal or written consent, is a best practice in telehealth. Medicare does not require informed consent for telehealth visits; however, some states do. Most states will require verbal consent. In fact, now under the COVID-19 emergency declaration, verbal consent can be given by a patient, since they initiate a virtual check-in and e-visit or telehealth visit. You should document that consent somewhere in your electronic health record. In some states they still say they want written consent, so you want to consider consent.

And you want to think through where you're going to put that consent. You don't have to have a written executed signed consent in most cases for your patient, but you should certainly document the consent in your EHR. And a lot of providers from what we've seen is they're using the chief complaint section of the progress note to document that consent.

And typically the guidance around consents is that it's an annual consent, so the patient can consent the first time they come in and do a telehealth visit. And after that you don't need to ask for consent anymore, but within a 12-month calendar year you should get another verbal consent or get written consent from the patient. Next slide please.

Luigi Leblanc: *slide 12*

So who is covered besides physicians? Medicare has a list of eligible providers who can provide telehealth visits and they are listed here. Physicians, nurse practitioners, physician assistants, nurse midwives, there's the typical providers there. Clinical psychologists and social workers are providers who are also recognized to do telehealth visits, but there are some billing discrepancies for them. Physical therapists and others too. And registered dieticians and nutrition professionals, those are the folks, particularly for diabetes management and chronic disease management, you want to get your nutritionists involved, so they can use that medium to do counseling and bill for the service.

Luigi Leblanc: *slide 13*

So this is a little bit about provider distant sites and what is considered an eligible site. And conventionally these facilities that you see on the list there in the next slide, the hospital, the nursing home, the Federally Qualified Health Center, your clinics, those are eligible sites, your public schools where telehealth visits originate.

You can also be a distant facility. What has been added is the home or where the patient resides or the patient place of residence is now an allowable distant site. Some states have additional sites or if some states are participating in alternative payment models or they've got some specific pay for performance programs like a health homes two initiative. You may find that states have added additional provider types that can provide telehealth services. So you want to check with your states if that is relevant. But from the commercial side to Medicare to Medicaid, what's key here is to know that home is now an acceptable, a permitted, originating site for a telehealth visit. Next slide please.

Luigi Leblanc: *slide 14*

So I want to talk a little bit about the health information exchanges in the region that Quality Insights QIO covers, Delaware, Pennsylvania, New Jersey and West Virginia. You all in those regions, there are

health information exchanges and those exchanges provide services that are really relevant in this era, in this time that we're in right now. They provide notifications of hospital events that have occurred for your patient, whether that's an ED event or an admission event or discharge event.

You can get those notifications and you may want to get those notifications to prioritize your telehealth encounter and who to reach out to and schedule visits for. They're also being utilized for example, in the district, the health information exchange in Maryland is being utilized by public health to notify a provider who participates of positive cases of COVID-19. So you would know if this is a patient of yours and the patient tested positive, so you can outreach them to do a telehealth follow-up visits. So check with your HIEs and see what services they provide. Next slide please.

Luigi Leblanc: *slide 15*

So just in terms of readiness, right now with the COVID-19, it's getting there and do it as early and fast as possible. You've heard what's allowable, you don't need a BAA, so it's a little bit like learning to fly while you're flying and why are you piloting the plane. But conventionally, when you're doing telehealth you want to do a readiness assessment of your originating site, or your distant site so that you've got the right equipment. There's the privacy controls, all those elements are in there.

You want to check with your malpractice carrier, that's really important even though Medicare is allowing telehealth visits to occur and reimbursing for it. You want to check with your malpractice carrier so that you make sure that telehealth is a covered service on the malpractice. We found that a lot of the carriers do permit telehealth to be a covered service.

What we are finding is that they may require that you to get a BAA. So again, for the Business Associate Agreement, check with your malpractice coverage to make sure that if you use a tool that doesn't have a BAA, can you be covered. And that should help set your action as well as how you do that. And then, look at your staff, look who you have, what resources you have.

I'm reminded from a conversation that I had with a provider, a pediatrician, that as a result of the pandemic they've been short of staff. So now everyone is answering the phones, they're doing it all. So for site readiness, I'm looking at your org chart. Your workflow is pretty important, if you're looking at this coronavirus crisis, but especially if you're looking at this as a standard of practice. Review your readiness in terms of your site. Next slide please.

Luigi Leblanc: *slide 16*

So if you're going to incorporate this into your overall model, use your electronic health record, it is a best practice today. Most providers are using an EHR to document the encounter. Make sure you're still using the EHR to document in the bill from your practice management side of the system, because the telehealth piece is going to give you the interaction that the patient is face-to-face, but your source of truth for your documentation.

And then also historically to know what's happening with your patient is in the electronic health record. So utilize that. You're going to find that your patients are very much going to appreciate the service, but you're going to have different types of patients. And I think the flexibility in the rule has been great in that, for the elderly population you can do a phone-only visit with them and that's wonderful.

And what we've found, even with the elderly population, you may start with the phone visit, but then when they get accustomed to doing a video based visit, they really appreciate that, it gives them a reinforcement comfort in a sense of engagement. So look at those things as well. And then with your specialists, those of us on the phone who are specialists, we know they could do a telehealth visit, there are certain types of vitals that you need.

And so look at the technology for the current state and your future state and evaluate how to make that more efficient. But currently if what you need is the blood pressure or you need the temperature reading or you need the glucose measurement from the patient based on their glucometer, they can take and share the measurements and for the clinically ill patient, you can look at them on the screen, it can show you the signs and you can see what it is. There are some specialties such as pulmonary where they want to see the EKG or the most recent EKG, and that may be a little bit more challenging for particular patients, but it's not an urgent case. But for those who are, if you're doing a telehealth visit, you might want to get from the PCP, the last EKG that the patient had done, then you can upload that and you can review that in the chart, I mean prior to the visit. Next slide please.

Luigi Leblanc: *slide 17*

Scheduling has always been a challenge in telehealth because a patient is scheduled for an encounter and now with the new flexibility in the rule, the fact that patients can actually do a telehealth visit and initiate it, you might want to look at the telephone only piece as the gateway in. So the patient calls and while you're doing the telephone encounter with them, you can schedule them for a telehealth visit at that time. And then that will be in the books so the patient can come back for a telehealth visit if the provider is not available. In some cases, for some of the practices that are PCMH certified practices and have 24/7 open schedules or you've worked that as part of it, then you can handle the scheduling in that way.

But scheduling is a process so when you're using any of these tools, you want to send the link to the patient so that they can actually connect for the visit. Some of you have it built into your EHR, in the portal, where it's scheduled.

I'm really close to wrapping up, so sorry about that. So just really quickly, again around the scheduling conventionally with the telehealth, assuming there's been a challenge in that with the new provisions allowable where the patient can initiate the visit. What you might want to do and consider is the patient may call in to the front desk to talk about the condition and that's a billable event now. And then you could use that opportunity to schedule the telehealth visit with the provider and engage the patient in that way.

So scheduling is something that you want to consider as you're looking into how you're going to fit that in the workflow in your current practice. Some practices that are PCMH practices and you've got open access where a patient can just walk in, then you may want to consider that as well. And how you do that in telehealth where I can just get a telehealth visit on the fly, if I call again, which is a billable event, then you can when the provider is available or you can actually just do a telehealth visit right there with the patient.

Luigi Leblanc: *slide 18*

So you want to factor in scheduling as part of that. I'll talk real quick about bandwidth and I recognize I'm over my time. What I would say around the bandwidth side is that it used to be in the '90s that it was a limiting factor, and not readily prevalent perhaps in some of the rural communities it's still a challenge. We had a challenge here, and I'm in a suburban community. But that still can present a challenge, but what you should know is that we're doing FaceTime and we're doing those interactions nowadays almost just as though it's the new routine normal day.

And so for the telehealth visit, the patient can do it on their mobile device. And so the bandwidth requirements that the providers or your vendor might say is out there, that is a lot, that is available, readily available by most phone carriers. Even if you have what you see, it says 3G, which is a smaller amount of bandwidth that most phones can do, then you can do a successful telehealth visit with that kind of bandwidth. So I wouldn't worry too much about the network access piece of it.

Luigi Leblanc: *slide 19*

Next slide around the device side. I won't talk too much about that, just to say test your equipment before you start the visits. Maybe daily check-in and test the equipment so that you can have audio and video. And if it fails at the end of the day, you can revert to the audio only and then finish that encounter, you won't get paid for a telehealth video encounter, but you can do audio visit and reschedule or do the telehealth visit another day. So check your equipment.

Luigi Leblanc: *slide 20*

There are some workflows and we won't get into that, but basically you'll need to develop a workflow for doing telehealth prior to the visit. How to prepare for the visit, what the patient needs to do, what you need to do the day of the visit, what you do post visit, the follow-up to close the encounter and bill accordingly. Next slide.

Luigi Leblanc: *slide 21*

If you're looking at doing telehealth as a standard of practice moving forward, which I would encourage you all to do, develop a nice brochure for patient education. You are going to find as providers who are now doing it, that patients really like this regardless of age. They like the flexibility, the sense of being able to reach you, the provider and that you're offering this expanded person-centered accessible service to them. You should develop a quick survey, a survey that gets feedback, so it's almost a human-centered approach to modeling it as you look to implement your telehealth business model. So try to get honest feedback from your patients.

Luigi Leblanc: *slide 22*

I'll conclude with this last slide by again thanking you all on the front line, and to say, please do this, it really will benefit you at this crucial time, it will help your patients out. If you do it now, you'll learn the nuances and you'll adjust accordingly. And if you want to do it moving forward, treat it like any new service that you would introduce as new business model, do some tests to make sure you plan accordingly.

The most important piece is what Kem is going to talk about, you can bill for it and keep your practice going. So thank you so much and my apologies for some technical shortcomings.

Kem Tolliver: *slide 23*

Okay. Awesome. Well, Luigi, thank you so much. This is Kem Tolliver everyone and I'm just making sure that you can hear me doing a mic check.

Kem Tolliver: *slide 24*

Okay, let's move on to the next slide. And April I'll let you take over advancing the slide. So thank you. So folks, what I want to talk about today is first I'll kind of piggyback off of the use of technology with telehealth and you can go to the next slide. When we're thinking, obviously there are some disclaimers as we all know, this information is changing. Gosh, it seems like by the hour, hopefully the information that we're presenting today isn't going to be outdated by the end of this program. But we have done our due diligence to try to get you the most up-to-date information from reputable sources. Next slide.

Kem Tolliver: *slide 25*

So I want to talk about the use of structured data. When we are considering using an outside, an external platform for telehealth services for documentation, we need to think about the transferability of that data back to our EMR. Some platforms only allow for PDF uploads of medical notes and this data format will not meet value based program reporting guidelines. That data needs to be structured and in that structure it needs to be formatted and aligned with the appropriate software fields of your EHR for your tracking and your reporting for programs like MIPS and APM and other programming reporting.

So please, when you're thinking about using a standalone telehealth technology that you will be using for documentation, just think about how you're going to interface that with your EHR if there's an open API capability so that you can have that structured data for your reporting purposes. Next.

Kem Tolliver: *slide 26*

Okay. So, well, we did touch on the provider licensing and scope of practice, but I'm going to just add a little bit to that. Now, I think what we're seeing is the federal government attempting to promote social distancing by expanding telehealth services capabilities, right? So they're relaxing provider licensing requirements, but it's still a good idea to check with your state on how those state regulations align with federal regulations.

Now, some states will allow providers to see patients without being licensed in the state where telehealth services are being provided, but other states won't. So you really need to check your state boards. Now, the good thing, I think for our patients to kind of help with that social distancing and not having folks be required to come into the office, is that the DEA has allowed for prescribing opioids through telehealth during this emergency.

But I want to make that very clear that it's during the emergency. So try not to rely on that being relaxed indefinitely. But the other thing you want to think about is I noticed that some practices have physicians or providers who are not interested in electronic controlled substance prescribing. The ECP, I'm sorry, the ECFP functionality. So make sure that the feature is actually turned on in your EHR if you are going

to be prescribing opioids during this time through telehealth. Most EHRs do have a cost associated to that feature. So you want to make sure that you check with your software vendor. Next slide.

Kem Tolliver: *slide 27*

So with the patient cost-sharing, again, the federal government is looking to increase social distancing by reducing the patient financial burdens related to receiving telehealth services. So as we know, CMS has waived that requirement for Medicare participating providers to collect those patient co-insurances and co-pays just during this emergency.

We all know that in the past it's been our responsibility as participating providers with Medicare to obtain those cost-sharing fees. But with the rules relaxed, we want to think about separating the Medicare guidelines from our commercial payer guidelines. Not all commercial payer guidelines are following CMS rules. So you want to check with them to see what their guidelines look like. The other thing that you want to do, I think operationally is find a secure remote method for your patients to make those payments when using telehealth services.

And you also want to think about, when do you want to collect those payments? Do you want to collect it after the visit? Do you want to collect it before the visit? My recommendation is to use your patient portal. This is your opportunity, while we're kind of reestablishing our technology optimization within our practices. Let's look at the long-term benefits for some of these restructures. Let's go ahead and use our patient portals to collect these remote payments from our patients. Going forward, it won't necessarily need to be just for co-insurances or co-pays, but in the future we can also use this technology for patients who want to pay on old balances. So consider looking at that as an opportunity right now.

The other thing to think about is when you're having these processes of remote patient payment collection, we also want to think about how are we going to remotely manage this, right? So your staff are working remote at this time, is there still going to be a reconciliation process? Make sure that the payments are posted correctly from a remote perspective. As we're thinking about our remote workflows, we also want to make sure that we have those checks and balances in place as well. Next slide.

Kem Tolliver: *slide 28*

Okay. So there's definitely been some confusion about place of service. And first of all, first off, Medicare is no longer requiring the originating site during the emergency, so we don't have to worry about that. Okay? Medicare and most commercial payers will recognize place of service 02 for telehealth services. But with Medicaid, you want to check with your state Medicaid because some state Medicaid are still recognizing place of service 11 with a modifier for telehealth services. So check with your state Medicaid, also check with your commercial insurances. But again, most of the commercial insurances will accept the place of service O2.

The other thing that we want to think about operationally is when you are at the claim level for claim submission. Most of us who are providing outpatient services, we're using place of service 11. So guess what, that's already hardwired in program into most of our technology in our practice management software. So what we want to do on the claim level is make sure that we make that adjustment from

place of service 11 to place of service 02 at the claim level. I've actually seen some software, some practice management software companies that require you to create a brand new department for telehealth services so that they can capture place of service 02. But again, look for that default in your software, make sure that you modify it appropriately for your place of service 02 telehealth services. Next slide.

Kem Tolliver: *slide 29*

Okay, so our modifiers, at this point Medicare is not requiring that we append a modifier to telehealth visits, which is a good thing. We do still need to indicate place of service 02 for Medicare. I would recommend that you watch your claims really closely from the clearinghouse level because the clearing house scrubbing edit may not have been modified yet. So if we are missing a GT modifier for a Medicare patient and we're using place of service 02, our clearing house may not have been updated already to waive that scrubbing process. So again, make sure that you take a look at your clearing house, talk to your clearing house vendors, and make sure that they are up to date with these new rules engines so that you don't have any claims being rejected inappropriately. Now, again some payers are going to still require the GT modifier, some state Medicaid will require the GT modifier, make sure that you're using that. But at this point, Medicare is waving it. It's not a requirement right now. Next slide.

Kem Tolliver: *slide 30*

Okay. So let's talk about the coding components of telehealth visit. So what I've listed here for you is kind of a breakdown of how to look at a telehealth visit from a coding perspective. Okay, so the first thing to think of is that the telehealth visit, it's a virtual face to face visit. So that means that you need to be able to see the patient. The service description they're an E/M visit.

Kem Tolliver: *slide 31*

Okay, so it's going to be your 99201, your new patients, through your level five established patients. We have the opportunity now to provide new patients with telehealth visits. Again, this all goes back to social distancing expansion. Now, for these telehealth visits, we have Medicare, most state Medicaid and commercial payers are paying for telehealth visits. The way that Medicare reimburses these services are the same as they would reimburse an in-person visit. So pull up your Medicare localities fee schedule and you will be able to get reimbursed the same amount for your telehealth visits as you would your regular E/M visits.

The restriction of new patients per patient status is waived for Medicare. We can see new and established patients for telehealth visits. There are obviously going to be some challenges with the exam for new patients. So you want to think about your documentation and make sure that the visit is medically necessary and just think about how you're going to adjust to the visits based on a new patient and the capabilities. Now, the initiating source for telehealth visits is going to be provider initiated. So this is not something that the patient initiate, the provider does. Next slide.

Kem Tolliver: *slide 32*

Okay. So the virtual check-in, this is again a remote ~~face to face~~ visit, but this includes some telephone components. This is more of a brief check-in with the provider, ~~when you're thinking about this, you~~

~~want to also think about the fact that the provider and the patient need to be able to see each other.~~ But these are really quick check-ins, they are for established patients only*. Medicare at this point is the only payer covering them with the G codes that I have listed here. And I've also listed the rates that Medicare will cover. Again, you need to check your particular Medicare locality because it varies by state to state. This is a ~~provider~~ patient initiated service. Next slide. *Addendum: face-to-face visual technology is not required for a virtual check-in visit. *On 3/30/20 CMS extended virtual check-in coverage to new patients, as well as established patients.*

Kem Tolliver: *slide 33*

Okay, so the e-visit, so this is a patient portal communication. And what I like about this is that we are able to communicate with our patients securely and remotely through that patient portal. So this is again a really good opportunity to leverage that technology to engage with our patients, not just during this emergency, but even after the emergency. This can really help with practice workflows.

It's a digital E/M, it's non face-to-face. I've listed the CPT codes for you. Medicare will pay for these services. Again, check with your other carriers to see whether or not they cover them. I've listed Medicare's reimbursement for this. The e-visits are going to be for established patients only because it's a quick check-in. It really wouldn't be applicable to a new patient. The initiating source for an e-visit is a patient. So the patient will communicate with you, will connect with you through the patient portal and that's how this service gets started. Next slide.

Kem Tolliver: *slide 34*

Okay, so the telephone services. Now I want to make a point of clarification. CMS, Medicare, will pay for telehealth visits at this time. Okay, so they will allow us to get reimbursed for that audio and video telehealth service. CMS does not have the 99441 through the 99443 telephone only without video on the Physician Fee Schedule. So if you are going to provide telephone services, you want to provide those telephone services only to your applicable commercial payers. These telephone services are for established patients only and the initiating source will be through the provider. So the provider will have to initiate the phone call to the patient. Next slide.

Kem Tolliver: *slide 35*

Okay, so there are going to be some non-physician telephone services and after this slide I'll show you which provider types are eligible to perform these services. Again, these are going to be services without video, so you are not required to see the patient. You can have clinical staff provide this service. I've listed the CPT codes for you. You want to check with your payers to determine which payers cover this service. CMS does not cover non-physician telephone services to my understanding. They are not on the Physician Fee Schedule. Again, this is going to be for established patients only, the non-physician provider may initiate this service.

Kem Tolliver: *slide 36*

And if we go to the next slide, I will show you the provider types who are eligible for the non-physician telephone services. Again, you want to check with your local carriers to see who else covers this, but these services are for physical therapy, occupational therapy, speech language pathology and clinical

psychologist. So that's another key component here is the need for behavioral health services. Now, this has been kind of expanded to allow for clinical psychologist to provide these telephone services. Next slide.

Kem Tolliver: *slide 37*

Okay, so our diagnosis codes. I've listed here diagnosis codes for COVID-19. What I will add to this is there is a positive COVID-19 diagnosis code. However, guys, we can't use it yet, it's not available until ~~October when the new codes come out for 2021~~. I did not document that code because I do not want any confusion as to whether or not you can code a positive COVID-19 right now. The codes that we have listed here are codes that are eligible for patients who might be suspected, patients who you're trying to rule out, who may have been exposed, who are traveling, who have a health complaint. And these are the codes that you want to use. Next. ***Addendum: The ICD-10 CM code for COVID-19 will be available beginning April 1st, 2020.***

Kem Tolliver: *slide 38*

Okay, coding conditions related to COVID-19. I just want to kind of put something into perspective here. We want to always code definitive diagnosis, right? So we also want to code the diagnosis as it relates to COVID-19 being applicable. So as you see here in this example the pneumonia due to coronavirus, what you want to do is if the pneumonia is suspected to be due to coronavirus, you want to add that additional specificity. And I've listed this here for you, your EHR software will break this down for you, but what you don't want to do is neglect to include the COVID-19 code when it is appropriate.

Kem Tolliver: *slide 39*

And I've given you some other examples. If you go to the next slide, again, we want to try to make sure that if there is a lower respiratory infection and it's related to COVID-19, that you add that additional layer of specificity. Again, just to remind you, coding rules suggest that the most acute diagnosis should be coded first. So when you're selecting your codes, you want to do that appropriately and make sure that you're sequencing them appropriately as well. We'll go to the next slide.

Kem Tolliver: *slide 40*

This is another example of coding for acute respiratory distress syndrome due to COVID-19.

Kem Tolliver: *slide 41*

Next slide. What you want to think about is you know for patients who are presenting with any signs and symptoms like a fever, and where a definitive diagnosis has not yet been established, assign the appropriate code for each presenting sign and symptom. So we do not want to give someone a diagnosis that they don't have yet, we want to code the appropriate signs and symptoms. Next slide.

Kem Tolliver: *slide 42*

Okay, so for documentation purposes what we want to think about is that when we are documenting telehealth services, we need to make sure that we're documenting the method in which the telehealth service was provided. That needs to be in our notes. Okay? We need to make sure that all telehealth services meet standard CPT and HCPCS E/M guidelines, they do not change, okay? We still have to follow those same guidelines. And if there is a time component, we want to make sure that that time component is documented. Now again we want to make sure that our documentation meets medical necessity as well. Next slide.

Kem Tolliver: *slide 43*

So again, when we're documenting the virtual check-in we need to document three things, we need to document the issues discussed during that visit, the plan that was developed by the provider as a result of that service and the total time of the service. That's for the virtual check-in. We move on to the next slide, the e-visit, very similar to the virtual check-in in terms of documentation. What issues were discussed? What plan was developed based on the information during that visit? And then we want to document the time. Next slide.

Kem Tolliver: *slide 44*

Same thing with our telephone visits. We need to have a summary of what was discussed during the call, what the plan is again as a result of that call, and the total time of the call. Next slide.

Kem Tolliver: *slide 45*

Okay, so I'm going to leave you here with some coding tips, okay? Obviously we're in a national emergency and telehealth is being used not just for COVID-19 patients and that's something I really hope to stress to you.

The point of social distancing is to encourage our providers to see as many patients as possible through telehealth. So we don't need to just see COVID-19 suspected patients. Okay? When we are documenting our social history, if it's applicable, we want to include exposure to others who may be ill within that social history if it's applicable to our patients, okay? Because then that starts taking us down the track of, "Okay, was this patient exposed to COVID-19?"

So think about that social history and the questions that you want to ask during your documentation. I talked about this already but again, let's not list a diagnosis if it's not definitive, we're only coding the signs and symptoms. As with any E/M service, our telehealth services need to be justified, and based on the level of our CPT code. It needs to be justified through our documentation along with that medical necessity. The other important component here right now is that there aren't any age limits for telehealth services. So we can see kids as patients and we can see elderly patients. There are no age limits right now, we're really hoping to increase social distancing. Next slide.

Kem Tolliver: *slide 46*

Okay, so in summary, Luigi talked about the technology, although the penalties for HIPAA compliance have been waived, we still want to try to use HIPAA compliance platforms. It's just a good practice even

though we have those you know, we have more flexibility, we still want to protect our patients. We also want to consider workflow modifications. Luigi had a great slide that talked about workflows and how you can incorporate them into your practice.

But again, think about how you are going to handle secure payment management of that and reconciliation, not just for now but for the long-term. And then as you're building out your telehealth service capabilities, you want to think about your templates. Does your software vendor require you to create a separate telehealth department in your EHR to document telehealth services? Are you going to be using an external telehealth platform that needs to be built out?

So think about all of these areas that you need to build out, but make sure that you have some coding guidance involved with that build out. But then also another really good option is to find a HIPAA compliant or HIPAA secure audio and video components that can be used directly in your EHR. So for example, Zoom for healthcare, you can talk to the patient, you can see the patient and the provider can just document right in the EHR. That's really best practice right now. Again, we want to make sure that our telehealth services are documented appropriately, and we want to follow the E/M coding documentation and reimbursement guidelines for all of our telehealth services. Next slide.

Kem Tolliver: *slide 47*

So this is my contact information, I know that we've provided you with a ton of information. Luigi and I are really looking forward to developing an FAQ document as a handout from this program. So please, please, please send your questions in the chat, they will all be downloaded and we will be answering them and sending them back to you in an FAQ document.

So thank you so much for your time, everyone. Good luck out there. Stay healthy, be safe. Thank you so much for everything that you do day to day, I know that it sometimes feels like a thankless job but you're doing great and you're really saving lives. So thanks for having us.

April

Well, thank you so much, Kem and Luigi. And again, all of the questions that have been submitted in chat and Q&A are being collected and as Kem mentioned, we're going to provide that Q&A document to all attendees by the end of the week. Please note when you close out of today's session, you will automatically be directed to a very brief evaluation. If you take a moment to complete it, we would greatly appreciate your feedback and comments. Thanks again for joining us today and have a great rest of the day. The session is concluded.