

Telehealth Learning Series Episode Four

NARRATOR: Hello and welcome to Top Telehealth Tips and Lessons Learned, part of the telehealth learning and discussion series for substance use disorder treatment and recovery support providers. This project is brought to you by the Addiction Technology Transfer Center Network, the Center for Excellence on Protected Health Information, the National Consortium of Telehealth Resource Centers and the Center for the Application of Substance Abuse Technologies at the University of Nevada, Reno in response to the COVID-19 pandemic.

Today's speaker is Kathy Wibberly, the Director of the Mid-Atlantic Telehealth Resource Center located at the University of Virginia, Karen S. Rheuban Center for Telehealth. Dr. Wibberly discusses the top five tips for billing and reimbursement of telehealth services.

KATHY WIBBERLY: So it's really hard to do top five for billing and reimbursement, but I do have my top, I guess, seven. And even that is probably going to be a little bit of a challenge, but we will see how far we can get. It is just truly complicated. And so if you feel like this is complicated, you're not alone. The reason that telehealth has not been just widely adopted until now is really because of this complication.

And so the first tip that I would ask you is take a look at your patient or client profile by payer mix, because you will not be able to learn every single rule all at once. So start with the ones where, if the majority of your patients are Medicare, start with Medicare. If the majority are your Medicaid program, start there. So that's kind of my first tip and get that figured out first and then move on to the next.

So Medicare fee-for-service telehealth is actually pretty complicated, but it's gotten less, slightly less so. So I'm just gonna hit on a couple of the key points for Medicare. So under Medicare fee-for-service the normal policy is that there's originating site restrictions. So you're limited by the types of facilities that can get reimbursed for telehealth where the patient is located. And also, that facility has to be located in a particular geographic location, rural and underserved.

Now, because of COVID, all of those restrictions have been completely waived, meaning the patient can be located pretty much anywhere in the United States. They could be at home. They could be sitting in their car. They can be sitting in a parking lot at a school, or they could be at a facility. But all those restrictions have been waived. So that's the number one biggest change with the waiver related to COVID-19.

Eligible services, unfortunately, have not changed that much. So under the normal before the pandemic, there were a limited set of services that could be reimbursed. That limited set got expanded each year. So CMS has this kind of request for additional services process, and you can, you know, add your justification for why they should expand it. And then each year they'll publish in the federal register what their decision is about a certain set of services.

So what they have done for COVID-19 has [UNAUDIBLE] a large number of services. So you'll see all the CPT codes that they've expanded it to. And that's great. But the next piece is the distant site provider. So Medicare and fee-for-service has a limited set of distant site providers

who are allowed to bill for telehealth services, physicians, NPs, PAs, nurse midwives, clinical nurse specialists, certified registered nurse, anesthetist, clinical psychologists, social workers, registered dietitians, or nutrition professionals, the end. That has not changed.

The only change as a result of COVID-19 has been the expansion to FQHCs and RHCs as eligible distant site providers. And even that is still a little fuzzy right now, because we're still waiting on guidance for how they're supposed to bill. Even though the whole list of eligible services hasn't changed, so the lesson learned is if you're a physical therapist, the codes for physical therapy have been added to the expanded set of services. But if you're a physical therapist, you're still not eligible, as a distant provider, to bill for those services.

So it's still limited to a physician billing for the physical therapy codes or the nurse practitioner billing for the physical therapy codes. So that being, that is a huge challenge, and it's gonna be a huge challenge for all of you because many of you don't fit in this group of distant site providers. The modality of what Medicare fee-for-service calls telehealth is synchronous audio and video two-way communication. That has not changed either.

What they have changed is what they use for a modifier. So before the pandemic, they wanted you to code all telehealth services as point of service or POS two. They discovered after this happened with the pandemic that if you put in the POS two code for those who are in facilities, it automatically takes away the percentage of the charge that's part of the facility fee and gives you just the professional fee, because, obviously, you're not using a facility. The place of service is telehealth.

And that has been a huge detriment. So they have reverted back to a very old modifier, basically saying use POS code as if it were an in-person visit and use modifier 95. So that is a big difference. They will still reimburse you for the POS two code if you use it. But you might not get the full reimbursement rate for some of you who are in a facility-based category.

Number three, then, is what probably is going to impact a lot of you. Medicare has restrictions on telehealth services. And over the course of the last two years, they have, and it's not because CMS does not want to reimburse for telehealth, but because a lot of this is in code and it's legislative. So there needs to be code change. And the code change has been very difficult after multiple attempts because of the budget neutrality requirement of OMB.

So what Medicare has done is made an attempt to develop a whole list of CPT codes, quote, unquote, CPT codes, that they are not calling telehealth. So these are actually Medicare fee-for-service, not telehealth services, so not to be confused with the telehealth services. So there is a virtual check-in service. There's a set of G-codes called Virtual Check-ins. They can be synchronous or asynchronous, and it includes phone. And it's intended to be quick, a few minutes, and the rate of reimbursement is really low. It's somewhere around that \$14, \$15 range.

But it was intended for patients to be able to connect to their provider and say, hey, you know, I was just in like last week, and my blood pressure's getting better. Or I got my meds and I'm feeling better. Great, don't need to come in then. So you can bill for that little bit of conversation with your parent, and if it avoids an in-person visit, perfect. You can bill for that 14, 15 dollars.

With COVID, they made allowances and created a set of codes where physical therapists, OTs, and SLPs FLPs? SOPS? can also use this virtual check-in.

The virtual check-in, unfortunately, is limited in the space to primary care practices. There's another set of codes called interprofessional consultation. And this is provider-to-provider consultation or what is typically known as e-consults. And so it allows, let's say, you're a specialist, or you are a mental health provider, and you want to connect with, let's say, an endocrinologist because you have a patient that has diabetes. And you don't want to spend 15, 20 minutes on that phone consulting about, let's say, medication management for this patient and not get reimbursed for this. So CMS has now created a code that will allow this interprofessional consultation to be reimbursed. It's not a huge reimbursement, but it's better than nothing. And so there is a set of codes for that.

There's remote monitoring services. And there is a whole set of different things. And there's no changes in terms of interprofessional consultations. So whether we are in COVID or not, there's no changes with that. Remote monitoring services has not changed either as a result of the pandemic. But there are a number of codes that you can use for remote monitoring of patients from their home. And the parameters around that will differ whether you're doing chronic care management, or physiological monitoring, or transitional care management.

There's also a code called online digital evaluation. And this is essentially using your patient portal for communications or review of recorded images. So let's say your patient has a skin rash, and they take a picture, and they upload it to the patient portal, and they write you a little you know secure email saying, hey I just discovered this mole, or this rash. Can you take a look at it?

So a clinician can take a look at those images in the patient portal and respond securely messaging the patient, saying, hey, that looks fine. Why don't you keep an eye on it? And we'll take a look at it again in six months. So that's like online digital evaluation. Now that, there's no changes in that as a result of the pandemic.

So what has changed is this telephone E&M service piece. So that CPT code has always existed, but Medicare had not flipped the switch on reimbursing anything for it. And now with a pandemic, they have enabled reimbursement for that telephone E&M service code. So that's the big change with the pandemic.

All right, so number four, state Medicaid programs. Basically, if you've seen one, you've seen one. And that is basically the hugest problem right now. Every state Medicaid program has administrative privileges to decide what they will and won't reimburse for for Medicaid for telehealth.

And so that is part of the complexity, especially if you're dealing with more than one state Medicaid program, or if you're on the border of three or four states, and you're on the panel for all those Medicaid programs. You will basically have to look at the guidance. Now with the pandemic, it makes it even more complicated because not only do you have the regular guidance, but then they have the emergency guidance.

And those things have been changing literally, like, for some states, every three or four days. They've been adding new service codes, adding new parameters, adding new things. So it's been really hard to keep up with those changes. My only word of advice for you is we try to keep up with it on our site for our states. But if you will just go to your state emergency management COVID-19 site, usually you have that, and it links to your state Medicaid changes and policy waiver changes, and go to the most up-to-date document.

What we have seen on the state Medicaid front spans the gamut. Some state Medicaid programs have said we do not want to hinder anyone. So all providers, if you're enrolled in Medicaid, you are eligible to reimburse for telehealth no matter what location the patient is at. And on top of that, if you can only have access to a telephone, we will reimburse you the full reimbursement rate, whether they're on phone, whether they're on video, or whether they're in person. That is the one extreme, but we have seen a whole bunch of states doing that.

To the other extreme, they've said, we're only going to reimburse you for secure video/audio only, and only for a set of services, and only for a certain period of time. So it really runs the gamut. And so I encourage you to stay on top of it. But we're seeing more and more states open up that. So they may have started really restricted and opening it up only to a certain set of providers or a certain set of codes. And as this pandemic has gone on, and they're realizing the impact it has had on patient care, they're becoming more and more lenient to what they'll reimburse for, who they'll reimburse for and the amount they'll reimburse for if you're not using video and audio.

This has been a challenge prior to COVID, and it continues to be a challenge. But part of the challenge is that states vary. So about 40 states and DC have private payer reimbursement, what's called parity legislation. That's a mandate that private payers who are on the commercial market, not necessarily for those who are like employer based or employer sponsored. If they're on the commercial market and your state has a parity legislation or law, then basically, if it's a covered service, they're required to cover it if it's provided by telehealth. Obviously, within reason, you can't do surgery by telehealth.

There is a huge variation even for those with parity legislation, because for some states they've written into the language both parity in coverage and parity in payment. And other states have just parity in coverage, but not necessarily parity in payment. And some private insurers have said, well, obviously, if a patient's not coming in, it's going to cost you less, so we're going to reimburse you less. That has not been a big trend. There's only been a handful of states that have done that. But be careful, because that can happen.

What we have seen with this pandemic is that a lot more payers are saying, hey, we'll cover even if our normal policy has not been to cover. And on top of that, we'll even cover you for like, a telephone consult. We're not going to require you to do audio, video. And so, again, the complexity is on the private payer level, it, just like state Medicaid programs, you've seen one private payer, you've seen one private payer, unfortunately.

And to make that even more complicated, private payers also have different modifiers that they use. So some use the GT modifiers. Some use the 95 modifier. Some use the O2. And there are a

handful that ask you to do both the GT and the O2. The worst part of this is you're going to have to contact each plan to ask them or find out from them which code they want you to use to indicate that it was a telehealth visit.

With that said, another lesson learned is that there have been traditionally some payers, I won't name names, that have contracted directly with a platform and a telehealth provider. And they have said to people, well, you need to join this platform for us to reimburse you. So even though you might have your own platform that you're using for your patients, you will need to be, participate with our platform provider even if you're just trying to provide care to your patients. And that has been a huge barrier. We've seen some of that barrier lifted with COVID. And so some of these big payers are saying, yeah, we don't care what platform you use now. But just know that that's out there, and it has been out there. And it may revert back after COVID.

So the last complication on the billing side is this managed care shared savings piece. It's basically for both Medicare managed care and Medicaid managed care. Most of those managed care plans are on their own. So they have been given basically, hey, it's up to you because you're bearing the risk, not Medicare or Medicaid, so we're gonna to give you a pot of money and you figure out what to do with it. And if you think you want to enable all sorts of telehealth, or if you want to enable telehealth to the home, or every code, it's up to you.

So the challenge here has been, one, educating the managed care plans on where the cost savings are to them and why this is really making a bottom-line difference to them. And then, two, helping them to put that language into their contracts for Medicare and Medicaid, because the agencies have said, it's up to you, just put it in your contract, and you can do whatever you want, because we're giving you this pot of money, and it's not going to bear us any burden. If you go over budget, you're only going to get this amount. So this has been a challenge as well. But we've also seen some of these managed care plans become more lax because of COVID-19 as well, and saying, hey, during this period of time, we'll do this.

It's the same with shared saving plans. So if you're with an ACO, ACOs basically have been given free reign, you do what you want, you figure it out, put it in your plan, and figure it out. Some ACOs have made huge provisions during COVID-19, and some have just stuck with their normal ACO operating service kind of policies. So you'll have to check with each one, and that, again, adds the complexity because it's multiple phone calls with multiple plans with multiple carriers to figure this out.

And it's asked to also talk about licensure. So this is not related to billing, although, somewhat related to billing. [LAUGHS] So on the licensure front, the standard rule of thumb is you need to be licensed in the state where the patient is physically located at the time of service. So that's always been the standard rule of thumb. There are some states that participate in interstate compacts. There are some states that have laws in the books about bordering states, allowing bordering state clinicians who have, let's say, practices in multiple offices that are in multiple states, or just basic bordering states.

Like, if you are on a bordering state, you have, you know, a compact with that bordering state. The majority of states don't have these compacts. So, also want to give you a word of caution.

Not all compacts are created equal. So the medical licensure compact is not truly a reciprocity compact. It's really just a, if your state participates, it's an expedited licensure process. So you still have to apply for a license, whereas a nursing compact or nurse practitioner compact, if you are participating in those compact states, it is a true reciprocity. Similar with the psychology compact. That has true reciprocity. So if you have states that are, at least for telehealth, it is.

And so you really need to kinda take a look at what state you are physically located in. And are you licensed in that state? What state is the patient located in? Are you licensed in that state? And then does your state participate in any of these compacts? And what does that compact language say in terms of whether you can practice in another state or not?

How this has bearing on billing and coding is that there are some Medicaid programs that, well, all Medicaid programs, will require you to be licensed in the state where the patient is located and where you're enrolled as a provider. There are a handful of Medicaid programs that actually say you have to be physically located in the state where you are providing services to get reimbursed by that state Medicaid program. So that's becoming less and less common. But all Medicaid and Medicare programs require you the provider to be in the United States or in a U.S. territory to reimburse. So if you decide to go on vacation in Europe, and you want to see your patients from there, you can forget about getting reimbursed during that period of time. Not that anyone's traveling during this period time, but that kind of is the rule of thumb.

We have created a resource page for this pandemic. We are Mid-Atlantic Telehealth Resource Center, so it's matrc.org. And if you go to that page, right up in front and center on that website, there's a COVID-19, you'll see the little icon with the virus image. If you click on that, that'll take you to our resource page for all of COVID-19. Down at the bottom is everything you want to know about policies, reimbursement, licensure, you name it.

NARRATOR: Thank you so much for joining us today. For a transcript of this podcast, presentation slides and other related resources, please visit our website site at www.telehealthlearning.org. This podcast is supported by funding from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and Health Resources and Services Administration. Its contents are solely the responsibility of the presenters and do not necessarily represent the official views of HHS, SAMHSA, or HRSA.

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In addition, content related to privacy and security and 42 CFR Part 2 presented during these sessions should not be construed as legal advice. And listeners are directed to discuss recommendations with their agency's legal counsel. Finally, listeners should consult SAMHSA resources that provide additional information regarding delivery and services virtually. Once again, thank you to our listeners for tuning in today. We hope that you'll join us again.