On-Demand Webinar: "COVID-19 Telehealth Waiver Made Simple"

Presenters: PYA Principal Martie Ross and Principal Kathy Greenlee

Original Webinar Broadcast: March 23, 2020 at 11am EDT.

NOTE:
This transcript was generated electronically. It has not been edited. It may contain computer-generated mistranslations, resulting in inaccurate or nonsensical word combinations. If you have questions about any particular part of this transcript or the on-demand recording please call PYA at 800-270-9629 for further assistance.

0:01
Good morning, everyone and welcome to today's webinar hosted by PYA a COVID-19 Medicare Telehealth waiver Made Simple. PYA is a leading Professional Services firm providing expertise and healthcare tax management consulting and audit and Assurance. We are pleased to offer you our thought leadership on this important topic.

0:27
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 with that. I would like to introduce our presenters Martie Ross and Kathy Greenlee.

1:01
Good morning, everyone. This is Martie Ross. I Am the managing principal at PYA's Kansas City office where we are 12 hours from the effective time of our shelter in place order. I am joined by my colleague Kathy Greenlee who is in the next office over, we're practicing appropriate social distancing. Good morning. By way of background I have been in health care for about 30 years. I spent the first two decades as a healthcare regulatory and transactional attorney and now have been working in the Consulting space. My colleague Kathy is the former assistant secretary for aging and the administration for community living at the US Department of Health and Human Services, and I'm just thrilled she is able to join us today and share some of her experience and knowledge. So I'm going to start us off with sort of the "how" talking about the Telehealth waiver.

1:59
Here's our agenda and these time estimates are our best guess I'm not sitting here with a stopwatch, but we'll talk about the Telehealth waiver will talk about virtual service reimbursements. We will touch on Medicaid and Commercial payers what they're doing and then Kathy will address engaging seniors and how we can get them participating in Telehealth services so that they are not for going Medical Care during this critical time.

2:27
And our goal is to leave 10 to 15 minutes to address your questions, which you can enter on the comment bar and we will monitor those as we move forward, so let's get started talking about new reimbursement for Telehealth services. So let's talk about life before the waiver. So before March 17 when the waiver was published Telehealth was created as a Medicare benefit back in 2001 and the relevant.

3:01
Of the Social Security Act is section 1834M. That's 1834M is a term you'll hear to help folks use all the time because it created restrictions on when this service could be provided and reimbursed for Medicare beneficiary. And you see here on the screen the for restrictions. The first is geographic that a patient receiving Telehealth Services had to reside in a rural area effectively a non MSA area. Secondly the location.

3:31
In requires that patients be physically present in a healthcare facility when the service was provided IE. Not at home. This also allowed for the rural facility where the patient was present to charge a facility fee. The third restriction was the service restriction which is a list generated by CMS of those services that are covered by Telehealth. They are listed by CPT code and HCPCS codes. It is updated annually.

4:01
We by CMS the list right now includes 100 Services Wellness nice exact round number and fourth limitation on Telehealth was a technology requirements that you have to utilize a telecommunications technology that has both audio and video capabilities and you have to allow for real-time interactive communication.

4:21
There are some minor exceptions to this which we're not going to address here, but just note that there are some exceptions to that general rules, but as you would not as you would have given thee Significant restrictions on Telehealth the actual delivery of this service in the Medicare program. The traditional Medicare program has been very very limited.

4:42
And in fact, it was well under one percent of Medicare beneficiaries receiving the service in the last report that CMS issued on the subject now in the last couple of years CMS has been creating exceptions under 1834M often with Congressional approval as a move forward the most significant probably has been the telestroke exception which started last year which lists the geographic and location requirements for services relating to diagnosing or treating a stroke victim.

5:14
The newest waiver is the substance abuse disorder waiver which allows for the lifting of the geographic and location Research into providing SUV or related to Behavioral Health Services end stage renal disease home visit home dialysis visits had Dude to tell how effective last year Medicare Advantage has always been permitted to expand the services. They'll reimburse for Telehealth beyond the official CMS list but beginning this year in 2020 and made plans have been able to expand their benefits to eliminate the geographical location requirements.

5:55
Also the Medicare shared Savings Program has some exceptions in its particular waivers of the geographic and Station requirements and then the sort of cmmi initiatives. So what we've had prior to March 17th was where this kind of Patchwork of exceptions that we were trying to continually expand the services. We saw real benefit, but with the waiver action by the secretary on March 17th, we've certainly expanded and where that waiver Authority came from was the coronavirus preparedness and response supplemental Appropriations act.

6:29
This was the law that passed On March 6th it mostly received press for the eight point three billion dollars.

6:38
It is infused in emergency funding to federal agencies to fight COVID-19, but the last section of the bill included this expanded authority to the secretary under the 1135 waivers to address the Telehealth Geographic and locations restrictions that did not include the authority to waive the services limitation and The technology requirements those remain in placed next slide, please.

7:08
There are series of documents that have been issued that are relevant to Telehealth waiver. We have them listed here. We have links to all of these documents. If you want to refer to them on our website on our COVID-19 Hub, but these documents together provide the guidance. So it's somewhat confusing you have to piece these different elements together next slide, please.

7:33
On March 18th, in addition to issuing the guidance facing to the providers CMS on March 18th set out an email to all Medicare beneficiaries to subscribe to my medicare.gov informing them of the availability of the Telehealth benefit. So not only are providers trying to figure out what's going on. In terms of the regulatory requirements are now receiving calls from beneficiaries to receive this email thing.

7:58
I want to schedule my Telehealth, so it's pressure coming from both directions next slide I would have next then go through the key elements of how you provide these Services Under the waiver starting with what are the covered Services first the Telehealth and if it is available only to established patients, however in publishing the waiver CMS made clear, they will not conduct audits to ensure a prior relationship existed for any claims submitted during this period also the legislation is now being debated in Washington as we speak.

8:36
I'm includes a provision that would eliminate patient established patient requirement. Secondly services. Do not need to relate to kovin 19. It is any service that you provide the until healthy providing face-to-face that is on this approved list would be available for reimbursement and finally Services as as we've mentioned previously. You have to be on the current year covered Telehealth Services list that list includes the typical off.

9:06
As an outpatient visits as well as ER and other institutional consult as well there. It also is on the list a number of psychotherapy codes as well as preventive services. For example, you can do an annual Wellness visit via Telehealth the list interestingly this not include home visits and that now we are providing services to patients at their home presumably, although CMS guidance is not crystal clear on this point one would be billing for those services with the outpatient office.

9:36
The codes next slide, please.

9:40
With regard to prescriptions does a very common usage of Telehealth is either updating prescriptions or securing prescriptions. The Controlled Substances Act actually prohibits a practitioner from prescribing of controlled substance absent an in-person medical evaluation. One of those key documents. It's been issued since March 17th is guidance from the DEA where they have waived this requirement during the National Emergency. However, they seem certain restrictions.

10:08

That the course has to be as prescription for a legitimate purpose. There has to be communication via Telehealth audio-visual communication system and they otherwise have to act in accordance with state law. And for that of course is the complication we have throughout this process is that the federal waivers are only applied to federal law. We are waiting then for Governor's to issue corresponding waivers that permit these different actions. So it's important in your state.

10:38
To ensure that you have an appropriate waiver of any state law limitations on Controlled Substances such as from your State Board of Medicine next slide, please.

10:48
Who can provide these Services back up, please? Thank you. If a provider can bill on the Medicare physician fee schedule for a face-to-face service under their own MPI. They can then build for the same service as Telehealth and here you have that list of providers some question with regard to whether incident to billing is permitted by Telehealth. These are non institutional settings because talk about the place of service code that CMS will need to provide clarification there on whether incident to Billings.

11:18
Committed and then our rural health clinics in federally qualified Health Centers today cannot build for Telehealth Services Physicians and practitioners who work primarily in rhcs and fqhcs. There are Arrangements that have been workarounds for providing services in ERS. I need use this probably use a similar arrangement for Telehealth services, but note that cares act again what's being debated in Congress right now?

11:46
It includes a new are Rhc. Fqhc Telehealth reimbursement. Although it does not set rates it at least provides the ability for those providers to be reimbursed directly through the rhc or the fqhc next slide, please.

12:01
Talk about technology and this is probably our biggest challenge. We still have to utilize a real-time interactive audio-visual communication technology telephone alone does not qualify. However, the office of civil rights that agency that enforces the HIPAA Privacy Rule issued a notification of enforcement discretion last week and they made clear that they will not impose penalties.

12:24
If a provider in good faith uses a non-public remote communication product, so So FaceTime Facebook Messenger Google Hangout Skype, all of those are permissible for using it for Telehealth communication provided that you've enabled all available encryption and privacy modes available on those different platforms what you can't use our public facing technology such as Facebook live or twitch CMS, excuse the OCR and Publishing this guidance encourage providers to notify patients.

13:00
These applications potentially induced privacy risks. They simply encourage it. It's not a requirement for using these different technology platforms, but this certainly opens up anyone with a smartphone is going to be able to engage in these Telehealth Services next slide, please.

13:19
Billing and payment is critically important to appreciate that service delivered via Telehealth must be built with place of service code. Oh to HIPAA can change the Telehealth world of who

years back. We used to use modifiers CMS eliminated the modifiers and replace them all with the place of service code O2. It does not matter where the provider is. It does not matter where the patient is at the time the services being delighted provided. It is always service.

13:49
Cotto to no other modifier is required unless you were previously using a modifier to provide Telehealth Services again under those exception programs and do not use the katastrophe disaster-related modifier the CR modifier. So for other waivers that CMS is issuing that permit certain Services delivered that would otherwise not be permitted. You are required to use the Dr. Or the CR modifier that is not the case for Telehealth Services.

14:18
You submit the claim aim to the Mac serving the practitioners location regardless of where the beneficiaries located beneficiary cost sharing applies co-payments and deductibles.

14:28
However, again initially in the guidance oig made clear that they would permit a waiver of copay deductible requirements for Telehealth Services importantly services are going to be reimbursed at the facility wait for the corresponding face-to-face surface, but if you are currently building non-facility the higher non-facility rate, you're only going Be paid the lower facility rate and also appreciate that if you're billing Hospital outpatient Department. There's not going to be a corresponding facility feed to build just how CMS has set up these requirements. Finally the issue of Medicare Advantage plan coverage. The general rule is an MA plan has to be for anything that additional Medicare pays for and thus with the waiver in a plans become obligated to provide services and provide coverage.

15:19
In the same manner as would be available to a traditional Medicare beneficiary how they want. That build will be a matter to be each plan would most likely resolve those issues there next slide, please.

15:33
Licensure requirements CMS has required that a practitioner providing any service must be licensed in the state where the patient is receiving the services. We refer to that as the originating site, but CMS issued a blanket waiver last week which waved the licensure requirements and thus under Medicare rules.

15:57
It appears you do not have to be licensed in the state where the patient is when you're providing to Health Services, there's some contradictory guidance from last year on this point, but it appears the consensus is that the Medicare requirement has been waived next slide, please. However again, this is that federal state issue state laws still require licensure to treat an individual via Telehealth in their state.

16:22
There is the interstate medical licensure compact that 29 states have signed on to that allows streamlined application processes that you would then License in one state and you go through the application process. You're going to be licensed the other 28 states to provide Medicare the Telehealth services, but appreciate there are also a number of Governors who are now issuing state law waivers under COVID-19. The center Port connected Health policy is maintaining a running list of those so you can find the links to them, but be careful because the terms of these waivers are varying significantly in fact here in Kansas 17:01yesterday Governor Kelly issued the executive order waiving the licensure requirements providing Telehealth, but in that notice, they're requiring still that the position provide written notice to the State Board of Medicine. And

also it only applies to physicians. We have not waived those requirements with regard to the other providers who can deliver Telehealth Services again, it's going to vary state by state make sure you're aware of what those requirements are. Next slide, please.

17:29
Let’s switch gears and talk about Medicare reimbursement for virtual services. So what is a virtual service? Well, CMS last year in 2019, or 2018 actually, they interpreted section 1834m is applying only to those services that are typically furnished face-to-face. It created this new category of virtual services to provide reimbursement for technology-based provider-patient relationship.

17:54
So the service wouldn't even exist, but for the availability of the technology and under this new reimbursement CMS takes the position that now the 1834M requirements apply and so virtual Services have been available as an option for providers before the waiver even existed. But let's highlight what these opportunities are. Next slide please. Probably the most important of these are the virtual check-ins. This is the telephone call, and really this is the only reimbursement available today under Medicare for strictly a telephone call.

18:28
CMS does not provide reimbursement under the telephone E&M codes the CPT 9941 through 43 Other payers do, a number of Medicaid programs do, but traditional Medicare does not provide reimbursement under those. Said, this new reimbursement which took effect January of last year. It's billed under the HCPCS codes listed here, and different kinds of 71 code for FQHCs

18:54
and RHCs. What this involves is a phone call between a physician providing services for 5 to 10 minutes, but with some restrictions in terms of the fact that you couldn't have had a visit so many days before and you can't have a face-to-face with scheduled so much time afterwards. It is low reimbursement. It's running about $13. Of course that varies based on where you're located and there are a lot of challenges here. It is established patient only and there are no waivers of that CMS is afforded.

19:25
So you cannot use communicate with a Patient via telephone and have any reimbursement available or it secondly, you must somehow documents patients consented. No, you don't need a written form signed by the patient, but there has to be documentation in the medical record that you discussed with the patient. That's bad. They consented to receiving this virtual service and there is no waiver of the co-payment injectable.

19:46
Again that broad waiver that CMS applied for Telehealth Services did not reach down and apply to Virtual check in so that creates another obstacle for the co but again, it's her only option if it's a telephone only communication next slide, please.

20:03
The other options CMS has referred us to re visits and this is even more challenging because this reimbursement was only introduced beginning of this year. And there is minimal CMS guidance even in publishing the Medicare physician fee schedule to create this reimbursement CMS was really narrow in its explanation of how these codes work. But this is a patient initiated communication via a HIPAA compliant platform. Primarily.

20:27

The reference here is to Patient Portal and also secure messaging then you have this issue of having the document verbal consent and no waiver the copay or deductible. These codes are measured by time as you see here. The reimbursement goes up before time. But again, this reimbursement is about half of what the reimbursement is for face to face visits for what the reimbursement under Telehealth service. So in challenge here that at least this gives us something in terms of email communication or portal communication between patients and providers.

20:59
This may be the easier place to direct patients for communication if telephone is the other only option. Next slide, please.

21:09
CMS also in 2019 created a new benefit for internet consultations that sort of a misnomer of a name because these also can occur by telephone but this reimbursement is intended to compensate for time spent between a treating physician and a specialist talking about a patient so that we can avoid the patient having to actually go to the Specialists office. So here again the requirement for documenting patient consent applies. There are two sets of codes. Well, actually there's one.

21:39
Code. The treating physician bills. They spend at least 16 minutes either interacting with The Specialist, or preparing to interact with a specialist or sending materials to the specialist. They can build for that time under this code. The reimbursement says about thirty-six dollars Then there are a series of codes the Consulting physician can bill for. These range in time from as short as five minutes up to more than 30 minutes the reimbursement ranges from $18 to $75.

22:09
Again, depending on location, amount of time to spent. Because if you intend to utilize these I would refer you to be predatory language because there are a number of conditions on how the service can be provided. Again, that's about our only source of CMS guidance. We do have an article on the PYA website talking about virtual services that walks through the particular requirements if you're looking to start utilizing these new codes during COVID-19. Again, there's no restrictions.

22:39
in terms of location on these, these existed separate and apart from 1834 and billing Next slide. Final virtual service we want to cover here is remote patient monitoring. These also began reimbursement last year in 2019. It's a series of now for codes that allow a provider to deploy a technology at the patient home, which remotely monitors the patient condition then affords reimbursement for the time spent by the practitioner.

23:09
Reviewing that data and acting on that data. This is a unique code because like The Chronic Care Management codes it permits that time spent reviewing data and acting on data to be performed by clinical staff. Provided they are under General supervision. IE not physical presence supervision by staff. So the RPM codes are providing a new opportunity, especially as we're monitoring patients that have conditions of patients that have been discharged from the hospital.

23:35
We can deploy the remote technology to Engage in that monitoring activity that also provides an opera an option and the reimbursement here is much more favorable than the other virtual

service code. So they provide an impetus for creating a remote patient monitoring program. Next slide, please.

23:56
We're going to cover very briefly Medicaid and Commercial payers because there are there are no consistent rules across these State Medicaid programs have a wide variation and their coverage for Telehealth Services prior to The COVID-19 emergency, in fact only four percent of Medicaid beneficiaries have used Telehealth according to the most recent data again Center for connected Health policy.

24:20
Excellent resource, they list current state laws and reimbursement policy and Determine their the level of coverage about different Medicaid beneficiaries within your state for Telehealth Services as part of the publication of the waivers, the Trump Administration encouraged states to provide Telehealth coverage noting in their guidance that no federal approval is required at the State Medicaid Program elects to reimburse Telehealth services on par with face-to-face Services.

24:48
However advises they would have to file a disaster State Amendment state plan Amendment if you intended to provide More restrictive reimbursement. Again yesterday, I believe CMS issued a new template for states to use in issuing that master state plan. So again, make sure you're aware of what's going on in your state. For example, Ohio, the governor on Friday issued a pretty broad waiver that permitted broader coverage for Telehealth services in their Medicaid Program next slide.

25:22
On the commercial side we look at the parity laws. 40 States including the District of Columbia have implemented Telehealth parity laws, which read it will require a payer to provide some coverage for a service provided via Telehealth to the same extent as provided via face-to-face, but only a handful of those State parity laws require reimbursement parity, and thus there may be coverage in these states.

25:51
For Telehealth services, but they're not going to have favorable reimbursement terms again a different resource here to refer to the American telemedicine Association on their website. They have the 2019 state of the state's report which goes through coverage and reimbursement on the state-by-state basis again, which is going to provide the foundation for commercial coverage. But really there is no centralized repository of commercial Payer Health commercial payer Telehealth coverage.

26:19
It is really a matter of hunting and pecking who your top payers and figuring out what their policy is going to be and many of these commercial plans are using third-party vendors as sort of front-line screening tools for patients and encouraging patients to reach out to these services to screen for basic issues before they even call their own doctor. So be aware that that often times become sort of a different type of Gateway into the provider relations provider Community there have been some State action.

26:50
They're requiring Regulated plans to provide tell of coverage Massachusetts. I believe on Friday, maybe Thursday issued an order that is requiring all state-regulated plans to provide equivalent Telehealth coverage similar to the federal waivers. And of course, you're seeing some plans voluntarily expanding emergency coverage as well in no centralized resource for

that at this present time. You'll just need to again check regularly with the providers in your community. So that sort of is a very quick and dirty way.

27:21
Through the Telehealth waiver as well as virtual Services what we're seeing out of Medicaid and Commercial plan again apologize for the technical difficulties, but I'm going to turn this over now to Kathy to discuss the engagement of seniors around Telehealth. Okay, come sit in my chair.

27:47
Good morning, everybody. This is Kathy me and my hand sanitizer are going to sit here and have someone help us Advance the slide. So let's start talking briefly about the Medicare beneficiary. The rule as Martie has described has required that Telehealth previously be provided at a health care facility the new rule and the waiver will promote and be framed as you can now deliver these services.

28:15
In the beneficiaries home. This also opens a third pathway that I think people should think about that's individuals who live in any sort of congregate housing setting they may need people may need facilitation.

28:28
And those congregate care providers can be great allies and about three examples that someone living in a Continuous Care retirement community where there's Assisted Living independent and skilled could set up a room where the people in independent and an independent in the assisted-living could come to the main building and have someone help facilitate a technology called either a telemedicine probably wouldn't need that for the virtual check in with your phone because the rural piece of the rule has been waived and we can now provide Telehealth services to people living in urban settings. You should also think about high-rises, senior high rises.

29:10
I'm convinced, just from other work, that the doorman in New York City knows everything that's happening in their buildings and many of those buildings just naturally have older people who kind of aged in place. So think housing more than Healthcare setting as you start to think about options the Department of Housing and Urban Development also has a number of HUD housing complexes for low-income seniors.

29:35
They all have service coordinators that could be points of contact to help facilitate a telemedicine connection virtual health Care appointment for the people living in their facility. So I think it's important to think about this as a new option because some people will need help next slide.

29:55
People on the other end of this connection are very heterogeneous. So I just want to call out a few things to keep in mind 16% of the Medicare population is less than 65 that totals about 8 million people. So we tend to think of Medicare as only older people. This is a Medicare benefit not an old people benefit.

30:14
So any patients who are on Medicare at a younger age will also have the opportunity to receive Services through Telehealth and those will do Generally be younger people they may or may not have more expertise or familiarity with using technology for virtual communication, but they certainly are different kind of population and then to keep in mind that 10% of people on

Medicare very old older than 85 more than half the people over 50 over 75 have hearing loss and only about a third of the people with hearing loss use hearing aids. So just being able to hear by using virtual.

30:53
Occasion I will really be give up an essential part of making that communication effective and don't assume that everybody will just easily be able to switch when they are used to seeing a doctor face to face to help with communication. And then of course the president prevalence of cognitive impairment not just people with Alzheimer's disease, but people who are just aging with an old brain who have natural cognitive decline some of those people live at home and some of them live alone and certainly anyone with an executive functioning.

31:23
Paramount, they sort of cognitive impairment will likely need some facilitation to take advantage of a Telehealth next slide, please.

31:34
So I would just encourage people to ask and not make assumptions about the ability of a Medicare patient to use technology. I mean, it would be a sweeping generalization to assume they can't many people will be able to but do not forget family caregivers their essential supports for older people and older person who's used to Bringing family caregiver or some sort of supporter with them to a physical appointment will also need to rely on that person for a Telehealth appointment.

32:01
But because of the the use of this Telehealth technology, there's actually an opportunity here to include in the Telehealth visit family members and caregivers who are physically far enough away that they don't usually come to a doctor's appointment. But you certainly could connect, you know, the daughter or son whoever multiple states away through a Telehealth call. And in that way facilitated, the telephone check-ins could also work and maybe sort of the Gateway in to do a virtual check in talk to the older person.

32:32
Some But be sure and include family that their essential even in telephone calls, not just the virtual business next slide.

32:44
Ultimately, this is going to be about older people being comfortable. So I looked for some recent studies in preparation for the webinar and 2009 in Michigan. They confirmed that older people really are more comfortable visiting a doctor's office. I don't think that's surprising. However, Natalie nearly half the people that they surveyed willing to try so older people are likely going to be willing to kind of work it out with you, but nearly 10 years ago now in 2011, there was another survey about older adults.

33:14
Perceptions and they were key factors that would make them comfortable and I think the most important one is the first one which is perceived usefulness provide us will have to do a lot of talking about why and then the second one how hard is it going to be? What is the effort that you are expecting patients to make in order to connect from their end why and how hard will be essential influence of peers? This particular study says this is peers their own age. Not their children.

33:44

But if everybody else insisted living is doing this this will create some peer pressure among older people.

33:49
That is something they can do that the confidential communication still exists through Telehealth and people will just have different degrees of anxiety about using computers and a physician's opinion also goes a long way my last slide then I think that just from my experience working with older people that mobile phone apps are likely to be the easiest for older people to use. Maybe the one that offers the most promise facilitated communication may need to rely on personal computers and laptops. I do a lot of work elder abuse Elder Financial exploitation. We're spending a lot of time telling people don't answer the phone. If you don't know who's calling, so make sure that you're not in a situation where you're trying to call explain.

34:36
Someone on Medicare and they won't answer because they don't know what you and then my favorite anecdote. I've got one to add to this. I was talking to a colleague of mine. He provides in some services in Los Angeles and she said they're finding there are a lot of older people who don't have thermometers in their house Martie and preparation for the webinar sent me some information about older people don't have telephones.

34:58
So I think if we're going to use this sort of Telehealth technology to reach people and if we think they're going to do any sort of self monitoring we have to ask very specific questions about what they have at home to help give basic Vital Information to providers. So I'm going to switch back to Martie. I know we're going to do Q&A. I'll Stick Around in case there's anything I could help with. Thank you all for participating.

35:30
QUESTIONS

Hey, thank you Martie. And Kathy now we're going to begin answering questions that were submitted during today's presentation. As a reminder you can still submit questions through the question pane in your attendee control panel.

35:46
Our first question is can providers perform Telehealth services from their home car or other locations since we have closed our clinics, or do they need to perform these services and a current CMS 855 registered location of our organization.

36:08
A great question and CMS is advised on this matter prior to the issuance of the of the waiver. They will permit the clinician to work from a location other than the official 855 filed location. That would permit one to work from home from one's car. When is hiding from one's teenagers that are at home not speaking from experience there at all or or other locations? So yes.

36:36
That is permissible.

36:41
Thank you. We have another question regarding commercial and Medicaid patients who require provider payer credentialing by Service locations for providers who can care for patients in a service location that previously payer credentialed. Will there be a modifier that can be used to

show that this was due to critical need due to the COVID-19 the outbreak of war was that specific to Medicaid and Commercial?

37:11
Yes, again, it's there is no uniform source of Truth with regard to State Medicaid programs or commercial payers presumably they are issuing guidance directed towards their enrolled providers.

37:30
I know several providers for example have received communication from the local Blue Cross Blue Shield with regard to tell a health coverage and the required documentation to Claims so what we discussed during this webinar in terms of including the O2 places service code submitting to your local Mac. All of that is limited to the provision of services for Medicare beneficiary, as you can expect potentially even different rules from the Medicare Advantage plans as they are required to provide the coverage, but they may have different billing rules for applying for these services.

38:14
Okay, thank you one additional questions. We had a request for clarification on renewing or refilling a controlled substance since that can't be done by just audio.

38:28
Correct the DEA guidance that was issued, again links for those documents are available on the PYA a website at our COVID-19 Hub, requires that it be an interactive audio-visual platform to take the place of the required based base evaluation prior to the initial prescription for a controlled substance.

38:58
You a note snack items that one can renew those prescriptions without required face-to-face visit. The controlled substance act restrictions to which they're making reference are only the initial prescribing of controlled.

39:18
Okay, thank you. We have one question looking for remote patient monitoring reference was made practice expensive only does this mean the practice must provide the equipment for monitoring. So glucose meter. Oh great question great question. There's pre COVID-19. There was a really a developing.

39:48
industry around the delivery of remote patient monitoring with third parties Contracting with Medicare providers to deliver the equipment and to provide the data monitoring and deliver reports back to the practice and allowing the practice to Bill under that nine four five three nine four five four codes because those are practice expense only codes and there's no requirement for physician engagement in Libya sisters. And so those arrangements have been taking hold it is then the 57 and 58 codes which are the actual taking that data analyzing that data acting on that data engaging with the patient. Those are the codes that require engagement of clinical staff under General supervision by a physician.

40:48
Some more challenging outsourced that we do have some experience in The Chronic Care Management space without sourced providers delivering those Services time similar Arrangements could be applied under the remote patient monitoring codes. Now that the general supervision requirement is put in place the beginning of this year before this year.

41:11
The RPM management codes required direct supervision clinical staff that effective January 1 CMS reduced that to General supervision okay, and one last question face-to-face usually include routine vital signs with Telehealth, there won't be an opportunity to include the vitals with the patient assessment how would this way in if the physician does not have the concrete information in front of him or her to provide services to the patient again that is inherent limitation of Telehealth that the laying on hands component of the practice of Something's obviously interrupted to the extent that go back to Kathy's example to the extent the patient has a thermometer at home or a blood pressure cuff and can provide that information to the position during the visit that certainly is helpful, but it is within the positions or the dance practice providers discretion there. They're actually the clinical decision-making Urban what they can and can't do with it.

42:24
available data That weighs issues of whether you meet the elements for a particular service and you'll have to be careful in evaluating the appropriate code to the signs of the surface. But definitely that is inherent limitation of these sub. It is a substitute at best to face-to-face care, but is an extension of the availability of those services in a crisis situation.

42:58
Okay, thank you right now. We'd like to thank our presenters Martie Ross and Kathy Greenlee. If you submit a question that we did not answer. Our speakers will reach out to you directly. If you have additional questions, their presentation and contact information will be emailed to you along with a recording of today's webinar. Also, if PYA can provide assistance, please call or email us. You may also visit our website www.PYAPC.com for more details about our specific areas of expertise or to subscribe to receive PYA insights. Please remember to stay on the line once the webinar disconnect to complete a short survey on behalf of PYA. Thank you for joining us and have a great rest of your day.