COVID-19: The Use of Telehealth in Long Term Care During the Pandemic

March 31, 2020

Webinar sponsored by:

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Applied medical research

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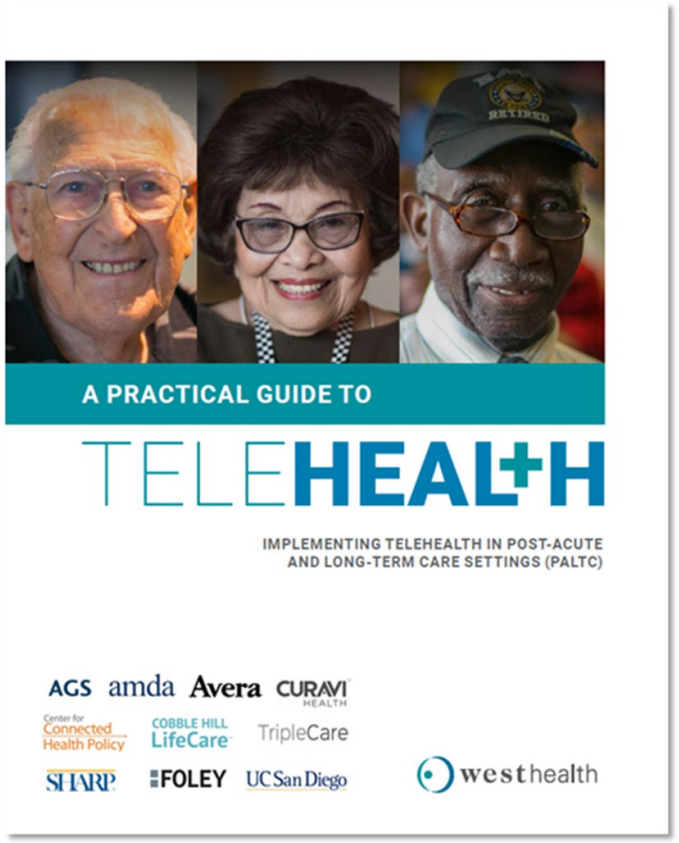
Policy research and advocacy

westhealth policy center

Download the free PDF:

www.westhealth.org/resource/telehealth-paltc-guide



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Agenda

Introductions

- Mike Kurliand, Director of Telehealth and Process Improvement, West Health

Message from California Association of Long-Term Care Medicine (CALTCM)

- Mike Wasserman

Use Cases and Lessons Learned from PALTC Implementations

- Steve Handler, MD, PhD, CMD, Chief Medical and Innovation Officer, Curavi Health
- Joshua Hofmeyer, Senior Care Officer, Avera eCare

Overview of Telehealth Policy and Coverage

- Mei Wa Kwong, JD, Executive Director, Center for Connected Health Policy

Facilitated Q&A

- Timi Leslie, Founder and President, BluePath Health

Wrap Up

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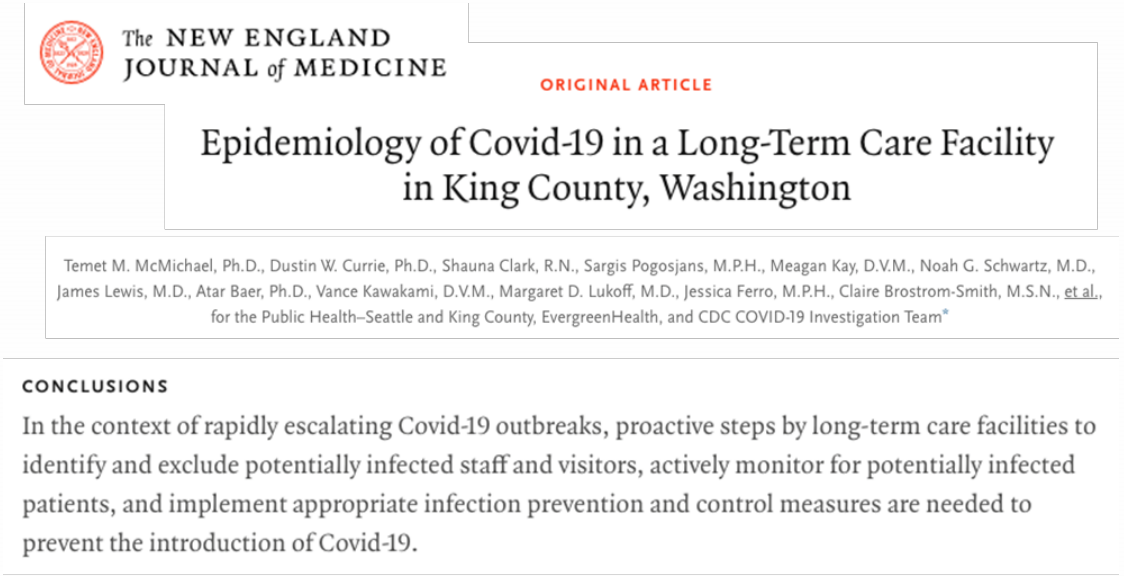
Message from California Association of Long Term Care Medicine Dr. Michael Wasserman, President



The NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Epidemiology of Covid-19 in a Long-Term Care Facility in King County, Washington

Temet M. McMichael, Ph.D., Dustin W. Currie, Ph.D., Shauna Clark, R.N., Sargis Pogosjans, M.P.H., Meagan Kay, D.V.M., Noah G. Schwartz, M.D., James Lewis, M.D., Atar Baer, Ph.D., Vance Kawakami, D.V.M., Margaret D. Lukoff, M.D., Jessica Ferro, M.P.H., Claire Brostrom-Smith, M.S.N., et al., for the Public Health–Seattle and King County, EvergreenHealth, and CDC COVID-19 Investigation Team*

CONCLUSIONS

In the context of rapidly escalating Covid-19 outbreaks, proactive steps by long-term care facilities to identify and exclude potentially infected staff and visitors, actively monitor for potentially infected patients, and implement appropriate infection prevention and control measures are needed to prevent the introduction of Covid-19.

T M McMichael et al., March 27, 2020:
https://www.nejm.org/doi/full/10.1056/NEJMoa2005412

JAMA Health Forum

Nursing Homes Are Ground Zero for COVID-19 Pandemic

Michael L. Barnett, MD, MS[1,2]; David C. Grabowski, PhD[3]

M L Barnett, D C Grabowski, March 24, 2020:
https://jamanetwork.com/channels/health-forum/fullarticle/2763666

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What we are seeing and how we are managing clinically and operationally

Steven Handler, MD, PhD, CMD
Joshua Hofmeyer, LNHA

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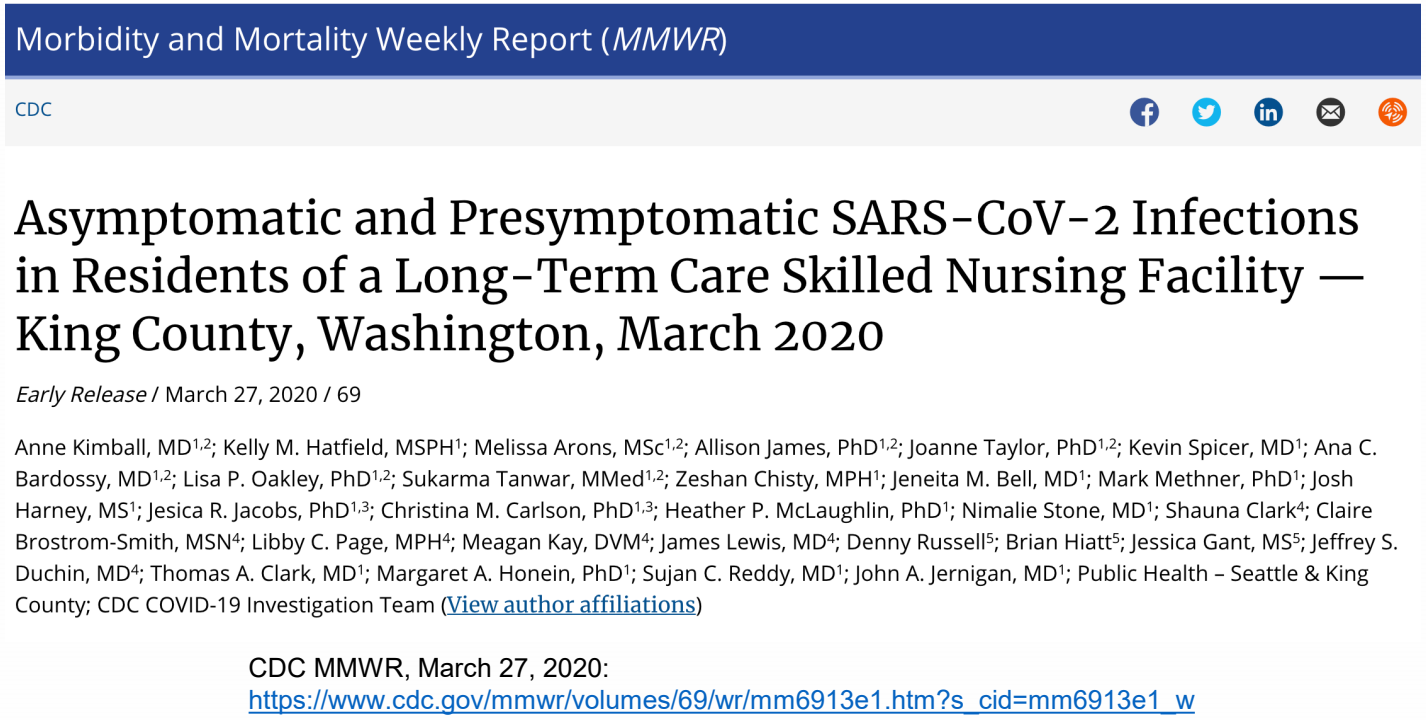
Looking for signs and symptoms of COVID-19

- Symptom-based screening may fail to identify all infections
- Symptom assessment may be harder for persons with cognitive impairment or disabilities
- SNFs can take steps to prevent introduction of the virus, including visitation restrictions, staff screening, use/ limited reuse of PPE
- Telehealth can prevent the number of people coming in and out of facilities



Morbidity and Mortality Weekly Report (*MMWR*)

CDC

Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility — King County, Washington, March 2020

Early Release / March 27, 2020 / 69

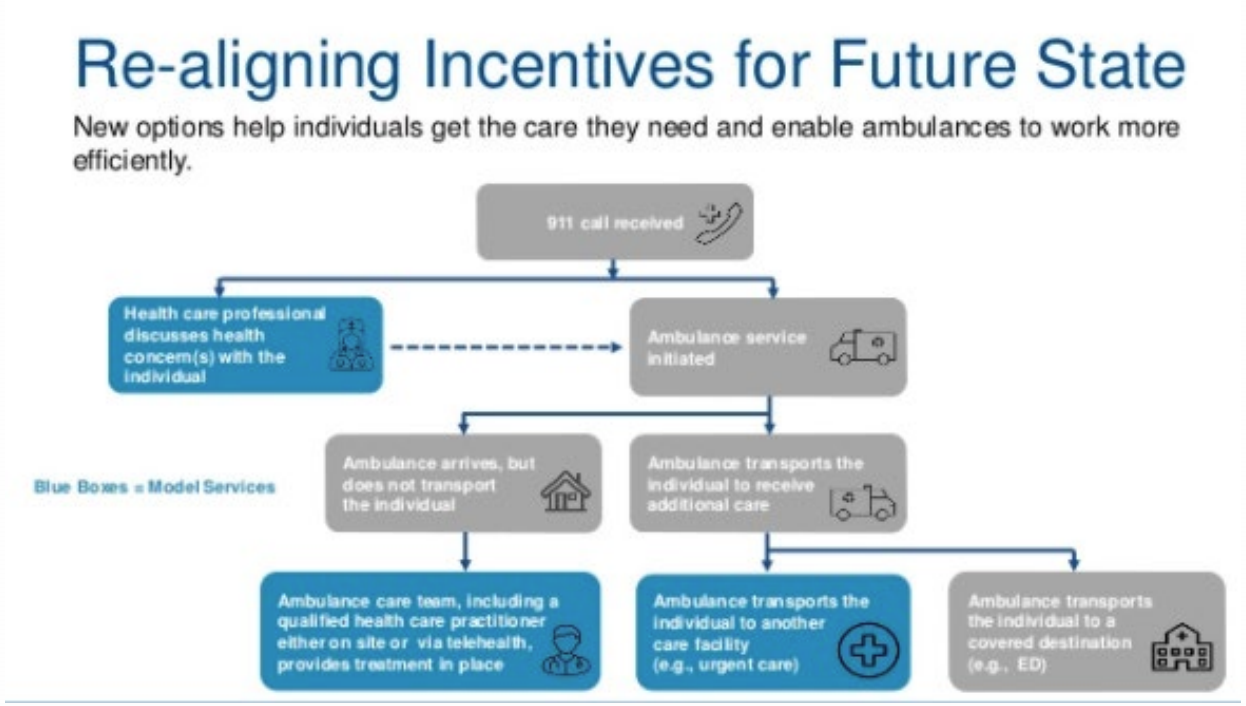
Anne Kimball, MD[1,2]; Kelly M. Hatfield, MSPH[1]; Melissa Arons, MSc[1,2]; Allison James, PhD[1,2]; Joanne Taylor, PhD[1,2]; Kevin Spicer, MD[1]; Ana C. Bardossy, MD[1,2]; Lisa P. Oakley, PhD[1,2]; Sukarma Tanwar, MMed[1,2]; Zeshan Chisty, MPH[1]; Jeneita M. Bell, MD[1]; Mark Methner, PhD[1]; Josh Harney, MS[1]; Jesica R. Jacobs, PhD[1,3]; Christina M. Carlson, PhD[1,3]; Heather P. McLaughlin, PhD[1]; Nimalie Stone, MD[1]; Shauna Clark[4]; Claire Brostrom-Smith, MSN[4]; Libby C. Page, MPH[4]; Meagan Kay, DVM[4]; James Lewis, MD[4]; Denny Russell[5]; Brian Hiatt[5]; Jessica Gant, MS[5]; Jeffrey S. Duchin, MD[4]; Thomas A. Clark, MD[1]; Margaret A. Honein, PhD[1]; Sujan C. Reddy, MD[1]; John A. Jernigan, MD[1]; Public Health – Seattle & King County; CDC COVID-19 Investigation Team (View author affiliations)

CDC MMWR, March 27, 2020:
https://www.cdc.gov/mmwr/volumes/69/wr/mm6913e1.htm?s_cid=mm6913e1_w

Forward triage: combining telehealth and paramedicine

- Triage can begin during 9/11 call, even before transport service initiated
- Paramedics can use telehealth to initiate remote treatment on-site, reducing need for transport and increased risk of exposure for patient
- CMS is testing this model through the Emergency Triage, Treat and Transport Model

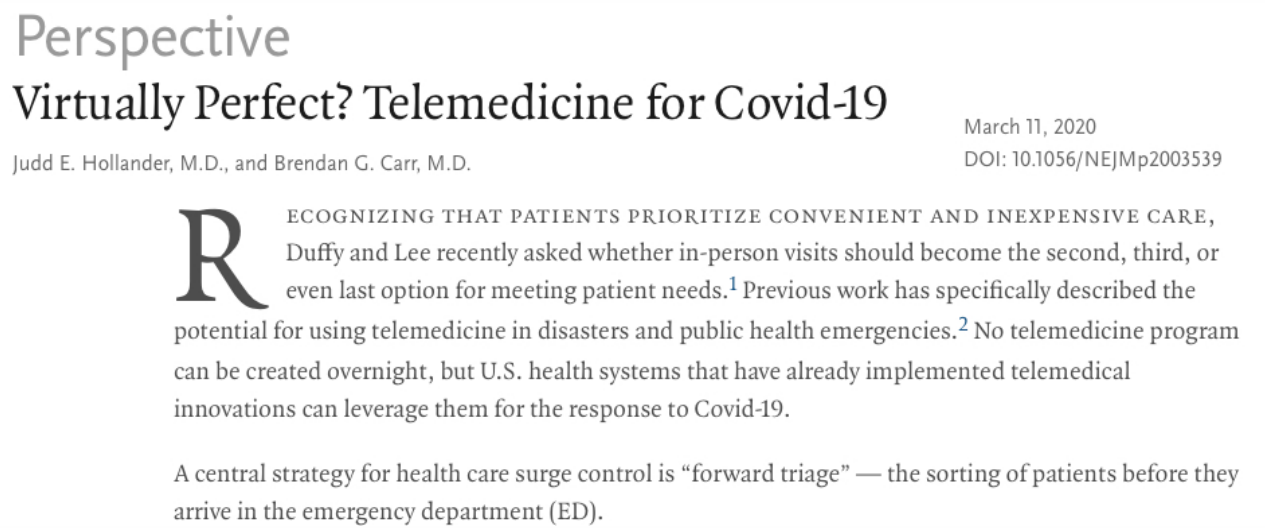
CMMI Emergency Triage, Treat and Transport (ET3) Model



CMS ET3 FAQ: https://innovation.cms.gov/innovation-models/et3/faq

Potential benefits of forward triage in the nursing home

- Extending the practice of Paramedics in times of resource constraint with UPMC TeleEmergency Triage
- Providing real-time decision support for emergent management of both adult and pediatric patients
- Assessing patients and allowing for alternative care destinations including non-transport
- Providing clinical guidance for emergent management and notification to the receiving facility
- Reducing risk to other patients and providers
- Improving patient and provider outcomes
- Improving patient and provider satisfaction



Perspective

Virtually Perfect? Telemedicine for Covid-19

March 11, 2020
DOI: 10.1056/NEJMp2003539

Judd E. Hollander, M.D., and Brendan G. Carr, M.D.

RECOGNIZING THAT PATIENTS PRIORITIZE CONVENIENT AND INEXPENSIVE CARE, Duffy and Lee recently asked whether in-person visits should become the second, third, or even last option for meeting patient needs.[1] Previous work has specifically described the potential for using telemedicine in disasters and public health emergencies.[2] No telemedicine program can be created overnight, but U.S. health systems that have already implemented telemedical innovations can leverage them for the response to Covid-19.

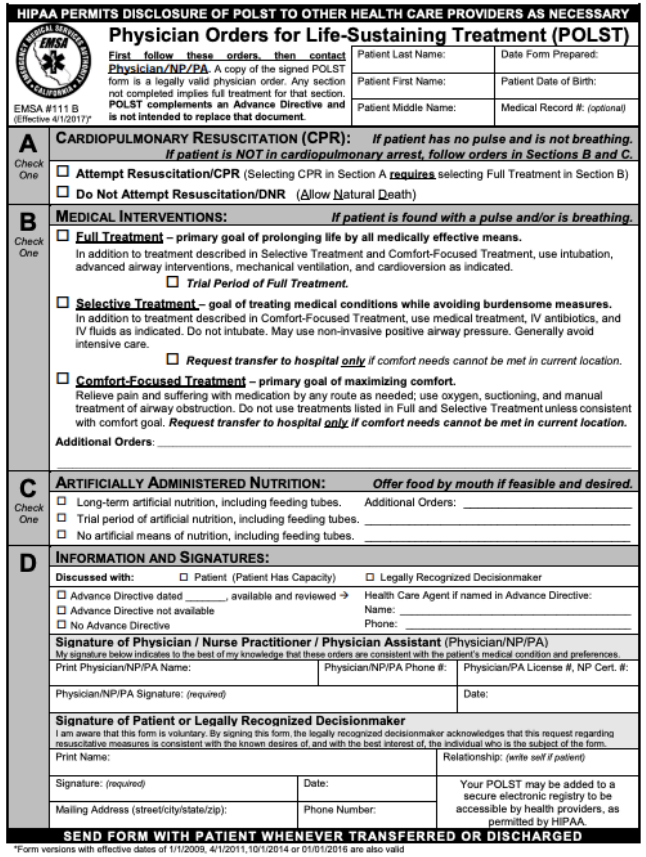
A central strategy for health care surge control is "forward triage" — the sorting of patients before they arrive in the emergency department (ED).

Centralization of staffing and clinical resources

- Provide a single number/point of entry for consult requests
- Ensure access to a qualified, responsive, knowledgeable and dedicated provider workforce
- Complete and share clinical documentation in a timely manner
- Standardize clinical approach using best evidence and most current recommendations
- Coordinate transitional care with pre-hospital transport

Goal-concordant care

- Residents should have discussions with their primary care team to ensure and drive goal-concordant care using frameworks such as:
  - Respecting Choices
    - https://respectingchoices.org/covid-19-resources/#planning-conversations
  - VitalTalk
    - https://www.vitaltalk.org/guides/covid-19-communication-skills/
- The end-result should be the development of advance directives such as:
  - Physician-Orders for Life-Sustaining Treatment (POLST)
    - https://polst.org/covid/
  - Five Wishes
    - https://fivewishes.org/five-wishes-covid-19



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 4/1/2017)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name: | Date Form Prepared:
Patient First Name: | Patient Date of Birth:
Patient Middle Name: | Medical Record #: (optional)

A Check One — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ *Trial Period of Full Treatment.*

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only** if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C Check One — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
☐ Trial period of artificial nutrition, including feeding tubes. _____
☐ No artificial means of nutrition, including feeding tubes. _____

D INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:
☐ Advance Directive not available Name: _____
☐ No Advance Directive Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name: | Physician/NP/PA Phone #: | Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: (required) | Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

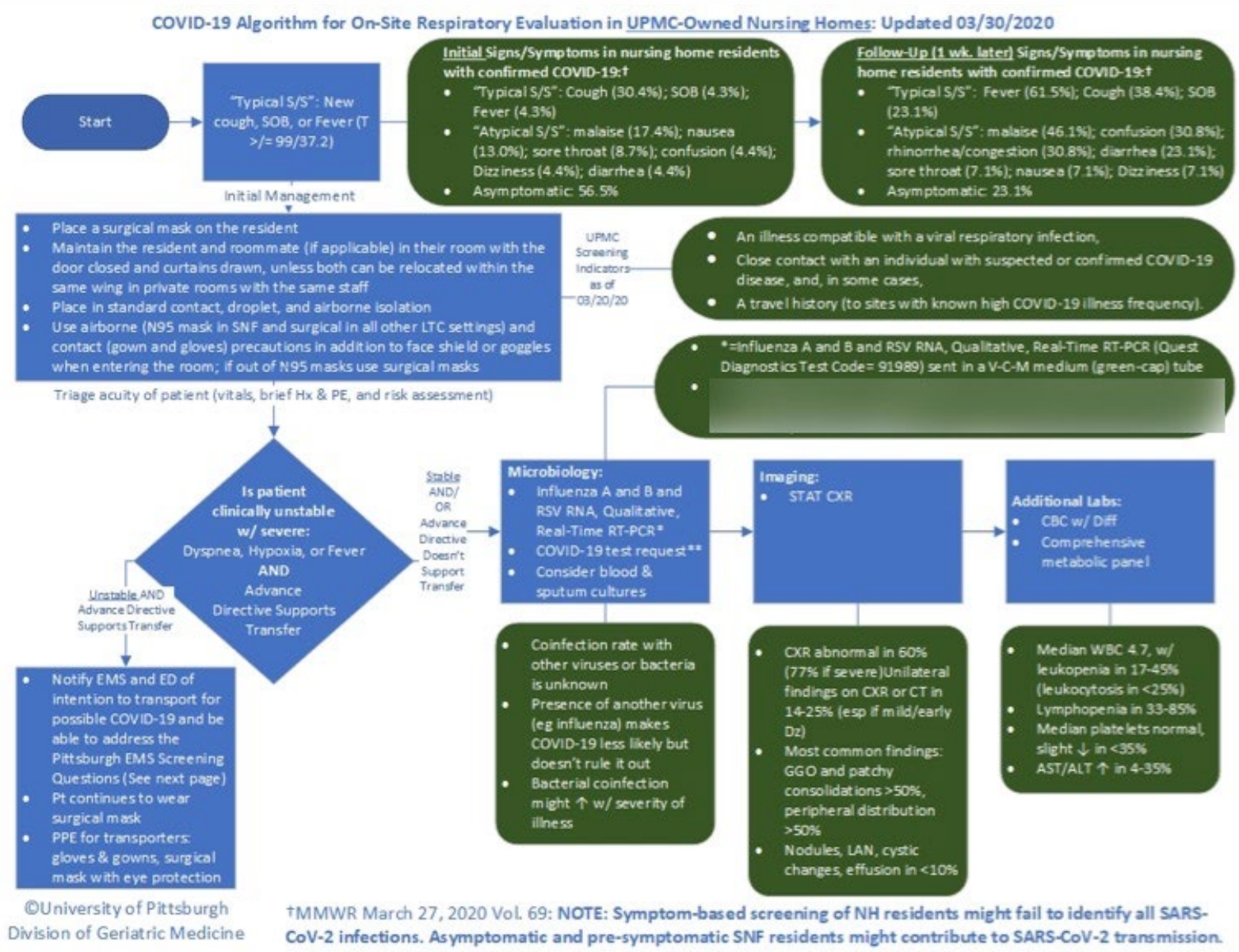
Print Name: | Relationship: (write self if patient)
Signature: (required) | Date:
Mailing Address (street/city/state/zip): | Phone Number:

Your POLST may be added to a secure electronic registry to be accessible by health providers, as permitted by HIPAA.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011,10/1/2014 or 01/01/2016 are also valid

Putting it All Together



Quick-start implementations examples and what you can do now

- Examples
- Consents
- Tools
- Workflows

Telepresenter: clinical staff to assist residents for remote visits

- Nurses, CAN's, EMT's and MA's can fill the role of "telepresenter" for provider-initiated live video telehealth.
- They facilitate the visit between resident and the remote health care provider.

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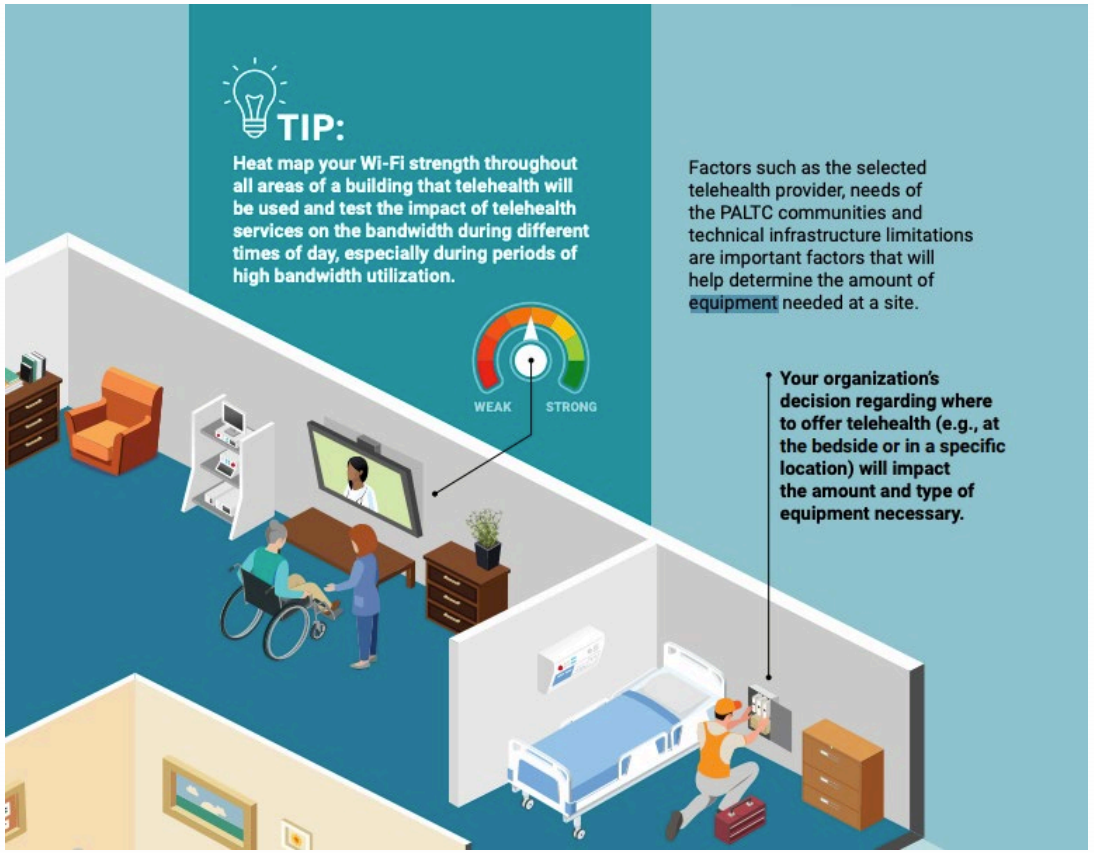
Equipment and software

- Location in the facility will you be using telehealth (e.g., at the bedside, another room)
- Equipment needed for that application (e.g., mobile device, A/V equipment)
- Sufficient WiFi connectivity for this application in that location

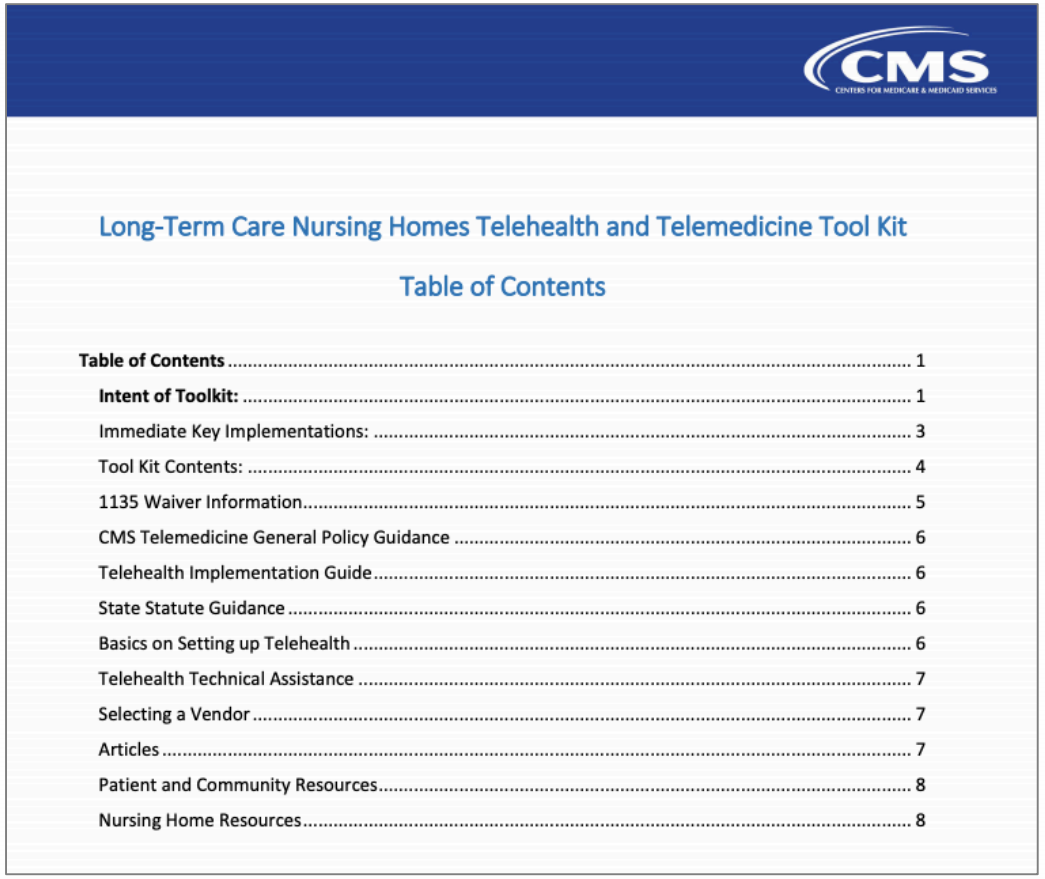


West Health Implementation Guide: https://www.westhealth.org/resource/telehealth-paltc-guide

CMS has developed a useful telehealth toolkit for long term care nursing homes

Guidance on

- Medicare reimbursement
- State law considerations
- Technical assistance
- Vendor selection



Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit

Table of Contents

CMS Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit: https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

HHS will not impose penalties for noncompliance with HIPAA in certain cases; CMS asks states to suspend nursing home audits

HHS OCR HIPAA update

- OCR will exercise its enforcement discretion and **will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers** in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.
- Must be “non-public facing telehealth”

CMS nursing home audit suspension

- CMS requests survey agencies suspend non-emergency inspections across the country

See CMS Guidance on Suspension of Survey Facilities: https://www.cms.gov/newsroom/press-releases/covid-19-response-news-alert-cms-issues-frequently-asked-questions-guidance-state-survey-agencies
See HHS OCR Notification: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

How to quickly pivot and key lessons learned

- Align on your key needs
- Based on those needs, identify whether telehealth is even part of the solution
- If yes, select a tool that can easily be deployed
  - Preferably one that exists already within your organization
  - Or one that is easy to purchase and deploy with relatively low or no additional contracting
- Identify one to two champions or leaders that understand the technology and pair them with people that understand the workflow
- Build a workflow that is easy to comprehend, understanding that you will miss some components right now
- Create training documentation that is simple and direct
- Monitor and adjust as needed, only addressing items that need to be addressed right now

Telehealth Reimbursement & Policy Considerations

Mei Wa Kwong, JD

Webinar sponsored by:

Telehealth & COVID-19

CALTCM & California Telehealth Policy Coalition
March 31, 2020

Center for Connected Health Policy®
The National Telehealth Policy Resource Center

Mei Wa Kwong, JD,
Executive Director, CCHP

CENTER FOR CONNECTED HEALTH POLICY (CCHP)

is a non-profit, non-partisan organization that seeks to advance state and national telehealth policy to promote improvements in health systems and greater health equity.

DISCLAIMERS

- Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.
- Always consult with legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.

ABOUT CCHP

- Established in 2009
- Program under the Public Health Institute
- Became federally designated national telehealth policy resource center in 2012
- Work with a variety of funders and partners

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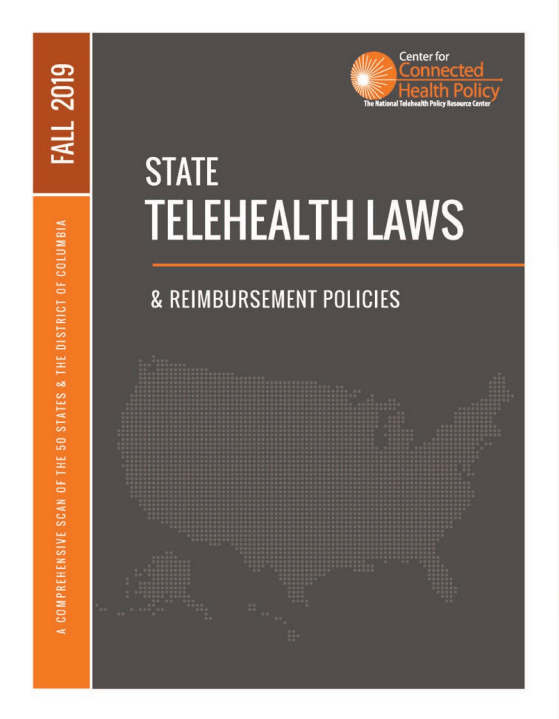
CCHP PROJECTS

- 50 State Telehealth Policy Report
- Administrator National Consortium of Telehealth Resource Centers
- Convener for California Telehealth Policy Coalition

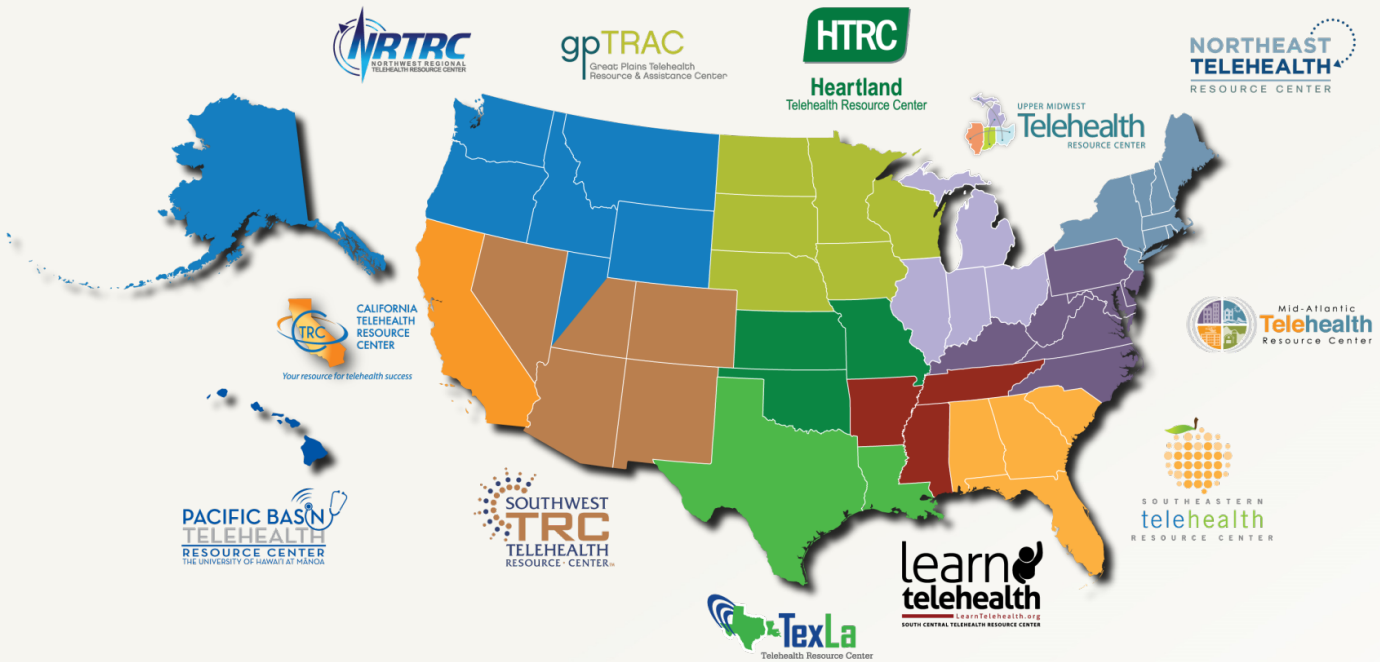


California Telehealth Policy Coalition

TRC
TELEHEALTH RESOURCE CENTERS

NATIONAL CONSORTIUM OF TRCS

TelehealthResourceCenter.org



TTAC TelehealthTechnology.org

Center for Connected Health Policy

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

TRC

TELEHEALTH RESOURCE CENTERS

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TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Search by Category & Topic

Medicaid Reimbursement

- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

Private Payer Reimbursement

- Private Payer Laws
- Parity Requirements

Professional Regulation/Health & Safety

- Cross-State Licensing
- Consent
- Prescribing
- Misc. (Listing of Practice Standards)

CMS TELEHEALTH POLICY - NOW

PRE-COVID-19	CURRENT STATUS WITH LEGISLATION PASSED & CMS CHANGES
Geographic Limitation (must take place rural area/non-MSA)	Temporarily waived. All geographic locations now qualify
Specific type of health site (specific list of eligible facilities and narrow exceptions for the home)	Temporarily waived. Other locations can now act as the originating site such as the home.
Eligible Providers (specific list of providers)	During emergency situation, FQHC and RHC added as eligible distant site providers (HR 748)
Modality – Live Video with Hawaii & Alaska allowed to use Store & Forward	At this time, no change. HR 748 removed language put in by HR 6074 that allowed telephone if it had audio/visual capability. This means the currently existing reference to "telecommunication systems" is in effect, but there is no explicit definition for it in federal law, though there is regulation. CMS thus has some flexibility to decide this issue. Will have to see what CMS does. Additionally, some services can be provided via "technology-based communications" that are not considered "telehealth" by Medicare
Services	CMS expanded list of eligible services provided via telehealth. HERE. EX: ED Visits, Level 1-5 (99281, 99285) Initial hospital care/hospital discharge (99221-99223, 99238-99239)

CMS TELEHEALTH POLICY - NOW

OTHER QUESTIONS	CURRENT STATUS WITH LEGISLATION PASSED & CMS CHANGES
Facility Fee (some exceptions to receiving the facility fee)	Follow pre-COVID-19 existing law.
HR 6074 said to utilize telehealth to provide services under the waiver, I need a prior existing relationship.	This requirement was removed by changes made in HR 748. Allowed to be used for new and established patients.
Do co-pays and out-of-pockets still apply?	Still applies, but the OIG is providing health care providers flexibility to reduce or waive fees.
How much flexibility do I have under HIPAA now? Is Facetime OK?	OCR "will exercise enforcement discretion and waive penalties for HIPAA violations." Keep in mind you may still have state requirements to meet. OCR guidance: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html
Licensure	Temporarily waive requirement in Medicare and Medicaid out-of-state practitioners be licensed in state where providing services if certain conditions met: enrolled in Medicare program, possess valid license in state that relates to that Medicare enrollment, providing services in state where there is an emergency and not excluded from practicing in that state. State requirements still apply.

CMS TELEHEALTH POLICY - NOW

OTHER ISSUES	CHANGES MADE BY HR 748 & CMS CHANGES
Dialysis Patients	Secretary has power to waive requirements that home dialysis patients receiving services via telehealth must have a monthly face-to-face, non-telehealth encounter in the first three months of home dialysis and at least once every three consecutive months.
Hospice	During an emergency period, the Secretary may allow telehealth to be used to meet the requirement that a hospice physician or nurse practitioner must conduct a face-to-face encounter to determine continued eligibility for hospice care.
Providers needing to put their home addresses	Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location.
42 CFR 483.30 requirement physicians and non-physician practitioners perform in-person visits for nursing home	If appropriate, the visit can be conducted via telehealth

CMS TELEHEALTH POLICY - NOW

OTHER ISSUES	CMS
Additional Codes for Reimbursement	Including initial nursing facility visits
Expansion of Audio-Only Services	CPT codes 98966 -98968; 99441-9944
Removal of frequency limits	Subsequent inpatient visit limit of once every three days (CPT codes 99231-99233); Subsequent SNF visit limit of once every 30 days (CPT codes 99307-99310) • Critical care consult of once per day (CPT codes G0508-G0509).
Stark Laws	Some waivers allowed for Stark including hospitals and other health care providers can pay above or below fair market value to rent equipment or receive services from physicians; health care providers can support each other financially to ensure continuity of health care operations
Supervision	Some supervision changes including allowing live video for physician supervision.

CMS Telehealth Manual: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

CMS FAQ - https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

CMS Emergency Declarations - https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

CMS Guidance - https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

TECHNOLOGY ENABLED/COMMUNICATIONS-BASED SERVICES

SERVICE	MODALITY	AVAILABLE TO FQHC/RHC
Virtual Check-In Codes G2010, G2012	Live Video, Store-and-Forward or Phone	Yes (use G0071)
Interprofessional Telephone/Internet/EHR Consultations (eConsult) 99446, 99447, 99448, 99449, 99451, 99452	Can be over phone, live video or store-and-forward	No
Remote monitoring services: Chronic Care Management (CCM); Complex Chronic Care Management (Complex CCM); Transitional Care Management (TCM); Remote Physiologic Monitoring (Remote PM); Principle Care Management (PCM)	RPM	CCM, TCM
Online Digital Evaluation (E-*Visit) – G2061-2063 Online medical Evaluations – 99421-99423	Online portal	No

OTHER FEDERAL TELEHEALTH POLICY

DEA

The declaration of the national emergency enacted one of the exceptions to the Ryan Haight Act for telehealth (telemedicine as it is referred to in the Act).

For as long as the Secretary's designation of a public health emergency remains in effect, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- *The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice*
- *The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system.*
- *The practitioner is acting in accordance with applicable Federal and State law.*

https://www.deadiversion.usdoj.gov/coronavirus.html

MEDICAID REIMBURSEMENT BY SERVICE MODALITY (Fee-for-Service)

Live Video

50 states and DC

Store and Forward

Only in 14 states

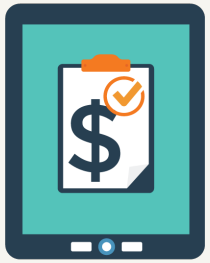
Remote Patient Monitoring

22 states

As of October 2019

Center for Connected Health Policy
The National Telehealth Policy Resource Center

REIMBURSEMENT REQUIREMENTS FOR PRIVATE PAYERS



40 states and DC

have telehealth private payer laws

Some go into effect at a later date.

Parity is difficult to determine:

Parity in services covered vs. parity in payment

Many states make their telehealth private payer laws *"subject to the terms and conditions of the contract"*

As of October 2019

COVID-19 WORLD STATES

- Common telehealth policy changes
  - Allowing home to be an eligible originating site
  - Allowing telephone to be used to provide services
  - Requiring health plans, managed care and private to cover telehealth services and offer parity

COVID-19 WORLD STATES

- Less common telehealth policy changes
  - Expanding use of other modalities besides phone
  - Expanding the list of eligible providers to include others such as allied health professionals
  - Waiving consent requirements, usual an adjustment made such as allowing it to be verbal consent

CCHP

- CCHP Website – cchpca.org
  - Telehealth Federal Policies - https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies
  - State Emergency Waivers/Guidances - https://www.cchpca.org/resources/covid-19-related-state-actions
- Subscribe to the CCHP newsletter at cchpca.org/contact/subscribe

Thank You!

www.cchpca.org

info@cchpca.org

Facilitated Discussion

Timi Leslie, BluePath Health

Facilitated discussion

Timi Leslie

Founder and President

BluePath Health

Please submit questions through the Q&A box.

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Appendix

FAQ (1/5)

I read that HIPAA is waived at this time. So does it mean, they don't have to be taken out of the room (even they have a roommate) when doing this?

HHS OCR has indicated that it will exercise enforcement discretion for non-public facing telehealth. (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html)

In our facility, we've been using Telemedicine already especially with this COVID pandemic. For new admits, we asks our Primary Physician to see and assess their patients within 72 hours upon admission. Can the MD use the Telemedicine on Initial visit?

CMS states: "CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform inperson visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options." (https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)

Can a CNA also be a TH facilitator?

A CNA can be a telehealth facilitator. Note that CNAs are not eligible for telehealth reimbursement. (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet_

With the HIPAA de-penalization, can a TH session be conducted over *any* video conference platform, including screen-based assistant devices, such as Alexa Shows?

HHS OCR's Notice states: "[C]overed health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules." (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html)

FAQ (2/5)

Can you please repeat what was said about Hospice telehealth visits?

CMS has stated: “CMS is allowing telehealth to fulfill many face-to-face visit requirements for clinicians to see their patients in inpatient rehabilitation facilities, hospice and home health.” (https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient)

Which CPT codes would be best for SNF inpatient h&p by MDs?

The appropriate HCPCS and CPT codes may vary depending on the service; refer to those listed by CMS in recent guidance. (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)

Are we still using same EM codes for admission and FU/discharges?

CMS has waiver some discharge and transfer requirements for post-acute and long-term care facilities but has not changed E/M codes for these services. (https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf)

Per our coding specialist, telehealth visits with face-to-face video component are considered equivalent to in person visits thus 9921X (e.g. 99213) E/M codes should be used? Is that correct?

Yes, CMS lists 99201-99215 as appropriate codes to use for synchronous telehealth visits. (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)

FAQ (3/5)

So monthly custodial SNF visits can be done via telehealth both for Medicare and private insurances? If yes what will be the CPT codes?

Private insurance requirements vary from state to state. CMS notes that telehealth can be used for the following services: Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337) (https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf)

We are using 99307-10 for subsequent visits. What about 99304-99306?

CMS has indicated that those codes can be billed for telehealth visits. (https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf)

We were recommended to use G0425-G0427 for initial H&P. Is this correct?

CMS has indicated those codes are to be used for initial telehealth visits for ED or inpatient visits. (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet)

Does anyone have experience to share using telehealth in a SNF setting? Any idea on financial investment for the facility to have telehealth capabilities? Main issue to me seems to be personnel at the SNF to facilitate the visit. Thoughts on this?

Several organizations have outlined how to measure ROI and fiscal impact of telehealth programs, including West Health. (https://www.westhealth.org/resource/telehealth-paltc-guide/)

Can you use the Telehealth to make a visits at skilled nursing facility more than every 30 days?

CMS has waived the 30-day rule for CPT codes 99307-99310 (https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf)

FAQ (4/5)

Is there any requirement for recording video or audio to get paid?

CMS does not have a recording requirement for the Medicare program.

What are HIPAA restrictions on type of device? We are planning on using tablets. Is there a certain type of device we need to use?

HHS OCR has indicated that it will exercise enforcement discretion for non-public facing telehealth. It has also listed platforms that advertise themselves as HIPAA-compliant. (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html)

How do we address the Physical Exam components of a visit via telehealth? Is there a reference site that can help address this? We're using time based billing/coding vs elements of the note but would like to have more guidance.

The physical exam performed at the originating site may be billable if it is a separate encounter.

Can the facility charge for the nurses time if she's spending 15-30 min to facilitate the visit?

The facility can bill for the facility fee using HCPCS Q3014 (https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf)

Please clarify what is meant by using certain "applications"? Are there certain ones that are approved or not approved? I.e is FaceTime okay? Or Zoom meeting?

HHS OCR has listed platforms that advertise themselves as HIPAA-compliant, and several that are not. (https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html)

FAQ (5/5)

How can I bill Medicare for visits performed over telephone?

CMS has indicated that virtual check-in codes can be used to bill for brief telephone check-ins, and that it will allow CPT Codes 98966-98968 and 99441-99443 to by provided via telephone. (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet; https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf).

Are there any recommended existing training documents that can help with quick implementation of telehealth usage, especially with regard to using telehealth for COVID-19?

Resources include West Health's implementation guide (https://www.westhealth.org/resource/telehealth-paltc-guide/), the E-Consult Toolkit (https://econsulttoolkit.com/econsult-covid-19-resources/) and the CMS Toolkit (https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf).