HRSA TELEHEALTH LEARNING SERIES

Telehealth and COVID-19

Monday, April 20, 2020 / 2:30 pm ET

Q&As

A. FCC COVID-19 Telehealth Program

1. *Phyllis Albritton*: Question for FCC speakers. Can you define the meaning of Community Health Centers in the law?
   USAC verifies whether an entity is a community health center by checking if it is verified on the HRSA website. (https://data.hrsa.gov/topics/health-centers)

2. *Stephen Neal*: Chad, can you let us know if this limits who can apply? Specifically Federal entities? The DLT was restrictive to non- federal entities.
   The only limitation on who can apply is whether an (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories.

B. *CCHP* - Telehealth Coverage Policies in the Time of COVID-19

1. *Rose Langdon*: There were new codes that came out today. Do you have those?
   There is the FQHC/RHC guidance:
   https://www.cms.gov/files/document/se20016.pdf

   The link to the codes that Medicare will reimburse for if the service is provided via telehealth are here:
   https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

2. *Diana Yoesel*: Is Medicare annual wellness a service covered thru Medicare telehealth?
   Yes, even before COVID-19, AWVs (G0438) was allowable over telehealth for Medicare. Here is the list of currently eligible codes:
   https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

3. *Caitlyn Hagarty*: Any hope for CMS reimbursing Medicare telephone-only?
   On April 30, 2020, CMS released an updated guidance allowing some codes to be provided by audio-only phone. If you go to this list, you will see which ones are labeled available to be provided via audio-only phone:

   https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

4. *Paul Faber*: With the new rules, can we now do an AWV using Telehealth and has the face-to-face visit with the provider been changed so the face-to-face contact can be done via video?
   Yes, even before COVID-19, AWVs (G0438) was allowable over telehealth for Medicare. Here is the list of currently eligible codes:

https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

5. *Michael ODell 3*: on a UB? or HCFA?
   The codes would be billed on the form where they are typically billed.

6. *Eleni Manousogiannakis*: Not all FQHCs are billing Part B. Is the billing information for Part B or Part A?
   The service would be billed where the FQHC typically bills the service, but the service must be one of the ones on this list:
   https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

7. *Ana Roscetti*: Where can I get the list of telehealth services that are reimbursable for FQHCs?
   https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

   FQHCs can bill for all those codes on that list.

8. *Tamara Morrow*: what G code prior to 7/1?
   If this is in reference to FQHCs/RHCs, instructions were changed on 4/30/20.

   RHCs
   Services provided Jan 27 – June 30, 2020 – Use G2025 with "CG" modifier.
   Services provided July 1, 2020 and afterwards – Use G2025, but with NO "CG" modifier.

   FQHCs
   Services provided Jan 27 – June 30, 2020 – For FQHC qualifying visits, the FQHC must report three HCPCS/CPT codes for the service:

   - Prospective payment system specific payment code (G0466, G0467, G0468, G0469 or G0470)
   - The HKPCT/CPT code that describes the services furnished via telehealth with the modifier "95" AND
   - G2025 with modifier "95"

   If the services are not FQHC qualifying visits, hold these until July 1, 2020 and then bill with G2025. Beginning July 1, 2020, FQHCs will only be required to submit G2025.

   The updated CMS guidance is here: https://www.cms.gov/files/document/se20016.pdf

9. *MERIN MCCABE*: Is there a published guidance you can link us to for the jan-june and jul-dec coding?
   https://www.cms.gov/files/document/se20016.pdf

10. *Kathy Pham*: How is "direct supervision" being interpreted during telehealth deliver of incident-to billing (99211-99215) if the team is not physically co-located? I'm asking on behalf of clinical pharmacists who were billing under those incident-to codes prior to CARES but with some regional variability between CMS administrators. Primary care pharmacists appear to be left out of the recent CMS flexibilities

CMS has said that: *"Consequently, they are revising the definition of direct supervision to allow, for the duration of the PHE for the COVID-19 pandemic, direct supervision to be provided using real-time interactive audio and video technology."*
(For the reference, see pg. 56-57: https://www.cms.gov/files/document/covid-final-ifc.pdf)

11. *Gabriela Ramos Torres*: Can Public Health Educators provide tele health? I don't have job from COVID19.
CMS updated their guidance as of April 30, 2020 to allow all Medicare health professionals eligible to bill. If a Public Health Educator is an eligible Medicare health professional and a service they provide is under the list of covered services when provided via telehealth, then they can bill Medicare. It may be a different story for Medicaid. The Medicaid policies would depend on the state.

12. *Richard Albrecht*: Is there any possibility of CMS allowing audio-only consultations for FQHC practitioners for the duration of the PHE? Many of our older patients do not have the capability to enable synchronous live video visits, leaving a significant access disparity during this time.
CMS updated their policies on April 30, 2020, and allowed some services to be provided via audio-only. See this list to find out which services:
https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

13. *Christina Higa*: Please review the requirement for CS codes.
From the CMS Guidance:
During the COVID-19 PHE, CMS will pay all of the reasonable costs for any service related to COVID-19 testing, including applicable telehealth services, for services furnished beginning on March 1, 2020. For services related to COVID-19 testing, including telehealth, RHCs and FQHCs must waive the collection of co-insurance from beneficiaries. For services in which the coinsurance is waived, RHCs and FQHCs must put the "CS" modifier on the service line. RHC and FQHC claims with the "CS" modifier will be paid with the coinsurance applied, and the Medicare Administrative Contractor (MAC) will automatically reprocess these claims beginning on July 1. Coinsurance should not be collected from beneficiaries if the coinsurance is waived. Expansion of Virtual Communication Services Payment for virtual com

14. *Michael ODell 3*: Questions. Could you please send answer to avaughn@schcmed.com FQHC billing: G2025 is this billed to Part A (UB)or B(HCFA)? List of reimbursable telehealth services? G code prior to 07/01/? Annual wellness visits via telehealth? See above answers.

15. *Jennifer McCormick*: Regarding documentation; even though the provider can use the FQHC address, do they still need to document that they are providing the telehealth visit from their home?
CMS did not say additional documentation would be required if the provider was providing the services via telehealth from his/her home.

16. *Donna Jennings*: What about post-covid billing for RHC and FQHCs? Any insight into potential use as a distant site or modifications in reimbursement for these venues?
These current policies are temporary waivers. We'll have to see what policymakers do.

17. *Margo Lalich*: What about school based health centers
Is this in regards to Medicaid or just using telehealth in general?

18. *Chelsea Phelps*: I know I should have asked during Mei's presentation, but when completing a telehealth visit via audio or non emr based video, is it required to obtain verbal consent prior to the visit? I ask this because my FQHC is concerned that with the billing aspect that patients are not aware that this a visit that generates a bill.
    CMS has said that consent can happen at the time of the telehealth visit. However, providers still can inform the patient ahead of time about potential costs and get the consent then as well.

19. *Donna Jennings*: CAH Method II-Guidance on employed provider billing for telehealth?
    Q. 18 - https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

20. *Kevin Rich*: When will the COVID19 CMS modifications return to the more restricted pre-COVID 19 restrictions? i.e are these changes permanent or temporary?
    At this time these changes are temporary and will end when the public health emergency is declared over. Will everything revert back to pre-COVID-19 policies, we do not know at this time.

C. *COEs and Avera* - Best Practices: An Inside Look at Using Telehealth During the COVID-19 Pandemic

1. *Phyllis Albritton*: Is Doxy connected to the clinic's EHR? If so, was that cost covered through your efforts?
   MUSC: Doxy.me is not connected to our clinic's EHR and is a separate web-based platform available to the general public at different cost points—including free—depending on the features selected. The inventor of Doxy.me is an MUSC faculty member that our Center for Telehealth works closely with. We were able to leverage this relationship to secure low cost instances for both MUSC as an enterprise as well as for the state through the SC Telehealth Alliance.

   Dr. Skow, Avera: No, Doxy.me is designed to work in parallel with any EHR. They suggest using dual monitors (one for your EHR, the other monitor for Doxy.me), split screen (with Doxy.me on one side, and EHR on the other) or use a mobile device for your Doxy.me call. Doxy.me has both free and paid versions. Costs of the platform are covered by the Health System or Local Provider.

2. *Rodney Moore*: Are the test 100% accurate?
   MUSC: The virtual urgent care screening for COVID-19 is a symptom based screening that determines whether a patient would be eligible based on CDC criteria at the time for actual COVID-19 testing done at a lab. The screening was mainly for triage purposes given limited availability of tests.

   Dr. Summers, UMMC: No tests are 100% accurate but physicians know how to incorporate that in their decision-making

   Dr. Skow, Avera: Tests that are based on their ability to detect a positive case, are sensitive tests, and their ability to determine a negative case, are sensitive tests. A sensitive test is going to be less likely to provide a false negative result. A specific test is less likely to provide a false positive result. Some research studies have shown that the accuracy of the current testing is around 70%. However, it is variable based on the type of test and the appropriate swabbing techniques. PCR tests are highly specific meaning if the test comes back positive there is a high degree of confidence

that the patient does have coronavirus. PCR tests can have an approximate 30% false negative rate, which may be caused by sample collection techniques. Antibody testing has also been instituted. By day 11-24 IgG antibodies can be detected in 90% of individuals. This allows clinicians to determine if patients have had exposure to Covid-19.

3. *Noel Taxin*: How did you lend equipment to patients without access?
   MUSC: In terms of our COVID-19 telehealth responses, we mainly lent repurposed tablets to those on inpatient units to use to connect with family members. Because these patients are inpatient, it is relatively easy to monitor the use of the equipment. For our other COVID-19 telehealth programs, i.e. conversion of ambulatory care visits, remote patient monitoring, and virtual urgent care COVID screening, patients use their own devices to access these services.

   Dr. Skow, Avera: Health systems have lent equipment such as peripheral monitoring devices and tablet computers. Patients sign a contract with their Credit Card number. The devices are free to use for a specified period of time. If the equipment is not returned the patient is charged.

4. *Sai Ma*: What devices patients use at home?
   MUSC: Patients can use their laptops, tablets, or smartphones for the Doxy.me and MyChart video visits, for the virtual urgent care screenings, and for the RPM COVID symptom tracking.

   Dr. Summers, UMMC: We send an inexpensive i-PAD to some patients that we do remote patient monitoring with but patient can also download an app to their computer or i-phone

   Dr. Skow, Avera: TytoCare Devices, Bluetooth Stethoscopes, Pulse Oximeters, Blood Pressure Monitors, Bluetooth Thermometers, Bluetooth Weight Scales, Otoscopes, Derm Cameras and Fetal Heart Monitors. Video connections are used through Laptops with embedded webcams, Desktops with external webcams, iPads/Tablets, and Smart Phones.

5. *Edward You*: How much is national security factored into implementation? For example, there was one occasion where one approved telemedicine provider utilized physicians from Israel and China.
   Dr. Summers, UMMC: We only use our own physicians.

6. *Jennifer Inden*: Is there a specific TeleConsent product/tool you use?
   Andrea Connor: Could we possibly have the TeleConsent tools used?
   MUSC: For clinical purposes, MUSC has incorporated our telehealth consent into our workflow for video visits using MyChart and documenting verbal consent when e-signature is not possible. For research purposes, MUSC uses Doxy.me for teleconsent. More information about teleconsent in the context of research can be found in this technical assistance brief developed by the MUSC Center of Excellence: https://muschealth.org/-/sm/health/telehealth/f/teleconsent.ashx?la=en

   Dr. Summers, UMMC: The University of Mississippi Medical Center leverages our EHR to identify patients for research projects and uses TeleConsenting tool to capture.

7. *Rose Langdon*: What is the cell phone company he mentioned?
   Dr. Summers, UMMC: CSpire Wireless; The University of Mississippi Medical Center’s Center for Telehealth has an existing/longstanding business relationship with CSpire Wireless which allowed our institution to quickly pivot to address the COVID-19 pandemic.

8. *Edward You*: Can see the vulnerability potentially growing as telemedicine expands?
   Dr. Summers, UMMC: Certainly, these things will change with time. At the UMMC Center for Telehealth, the quality and safety of our clinical programs is the driving design principle of virtual care delivery. If it does not make sense for us to do it with technology, we simply do not do it. From a clinical delivery, program design, and technology perspective, we make sure patient safety, secure data, and clinical approaches meet our institution's high quality standard.

9. *Reema Naik*: This question is for all the speakers who are sharing their telehealth experiences: What has been done to support patients with chronic disease and management of the disease? And What has been done to care for patients who are planning for preventive screenings (cervical cancer, mammogram, colorectal, etc.)
   Dr. Summers, UMMC: UMMC is uniquely positioned to address our patients with chronic diseases due to our Remote Patient Monitoring Program infrastructure.

   Dr. Skow, Avera: COPD, CHF, Cancer, Hospice, OB, Diabetic and other at risk patients utilize @Home Telemedicine programs for scheduled weekly appointments. Preventative screenings have been delayed due to the Covid Surge with plans to re institute them on the downward curve.

10. *Leslie deRosset*: Do any of the presenters have information on how local health departments in US are working around COVID 19, telemedicine and family planning services?
    ***Dr. Summers, UMMC*:** In Mississippi, UMMC is uniquely positioned in its capacity to collaborate with the Mississippi Department of Health. The Mississippi Department of Health shares the same EHR as UMMC and is on the same instance. This allows both groups, both with state-wide reach, to closely coordinate care delivery. Our Department of Health is currently working with us to long term, position all of its location to be able to be sites of care for telehealth.

11. *Jennifer McCormick*: Regarding providing Annual Wellness Visits through telehealth: How do we get height, weight, BMI, Blood pressure, etc.
    Dr. Summers, UMMC: Our I-Pad systems have those attachments.

    Dr. Skow, Avera: Through the use of Bluetooth enabled peripherals as described in question #4

12. *Demetrice Smith*: Do the patients keep the fetal heart monitors at their home?
    Dr. Skow, Avera: Yes, they are lent to patients until they can safely be seen by in person providers.

13. *Jennifer Inden*: what steps have you taken to ensure your geriatric patients have video/audio connections available?
    Dr. Skow, Avera: Geriatric patient who don't have access to smartphones, laptops, or tablets are lent equipment. The Geriatric population is given tablets tailored for ease of use with preloaded programs. These patients are virtually trained by staff on how to utilize the Tablets.

14. *Jennifer Michener 2*: Is there are recommended platform for rural populations? I work for the Indian Health Service and we are currently restricted in the types of platforms we can use, but find that network based platforms are not working well. We are approved to use Zoom, but I heard there were issues with security braches on this platform.
    Dr. Skow, Avera: There are no specific telemedicine platforms specifically for rural. Both rural and urban centers use similar platforms. Ease of use is a key factor in audio/video connections. Avera eCare uses Cisco or PolyCom units for CAH Emergency Departments, with over 450 cameras. This

AV equipment is a fixed and hardwired unit. With the push of a button on the wall an audio/video connection is made and controlled by the distant site.

If you are restricted to specific platforms, leveraging existing technologies and utilizing your internal IT support team to troubleshoot network-based platforms is important.

There are many platform options. The best options are HIPAA compliant platforms, in addition to platforms that integrate with an EMR. Despite the federal waiver to use non- HIPAA complaint platforms, health care providers and systems could potentially be held liable for HIPAA breeches. Zoom does have a paid version that is HIPPA compliant.

15. *C.J King*: I am listening in rural mountainous SE VT. Bandwidth is a major problem for telehealth. What is the minimum required for services such as Dr. Skow has outlined?
Dr. Skow, Avera: Bandwidth required for mobile direct to consumer visits, such as Tablet/Computer @Home visits, is a minimum of 3 to 6 MB/s for both Download and Upload speeds. For hard-wired fiber connectivity minimum speed is 10 Mb/s. When consumers are using Wi-Fi connectivity it is important for them to check their bandwidth using an app such as Speedtest and most of the mobile platforms will have Video testing prior to patient encounters. Patients can improve their bandwidth at home by limiting steaming services and gaming during their video encounter.

16. *Edwin Montero*: If a patient is able to connect to the telemedicine app (zoom, doxy, etc) via video, but they is having problems connecting/allowing audio. Can the telemedicine visit can be completed via phone with the video over the telemedicine app?
Dr. Skow, Avera: Many applications have a chat function so when video does not connect physicians and patients can enter chat through a text box. At the start of an encounter, the phone number is identified of the patient and if the telemedicine connection is lost it can be continued over phone when needed.

RESOURCES:

- VIDEO: CMS COVID-19 Telehealth Policy Updates to Medicare
- CMS RHCs and FQHCs: https://www.cms.gov/files/document/se20016.pdf
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs): CMS Flexibilities to Fight COVID-19: https://www.cms.gov/files/document/covid-rural-health-clinics.pdf
- CCHPA FQHC and RHC Guidance: https://www.cchpca.org/sites/default/files/2020-04/CMS%20FQHC%20RHC%20FACT%20SHEET%20FINAL%204.17.20.pdf
- Agency for Healthcare Research and Quality Telehealth Consent Forms: https://www.ahrq.gov/health-literacy/obtain-consent-telehealth.html
- MUSC COE TA Document re: Teleconsent: https://muschealth.org/-/sm/health/telehealth/f/teleconsent.ashx?la=en
- Pediatric Resource Billing COVID: https://www.aap.org/en-us/Documents/coding_factsheet_telemedicine.pdf