ARIZONA TELEMEDICINE PROGRAM

SOUTHWEST TRC TELEHEALTH RESOURCE · CENTER™

Improving Access to Quality Medical Care Webinar Series

Presented by

The Southwest Telehealth Resource Center, Arizona Telemedicine Program, and the Arizona Department of Health Services

Land Acknowledgement

We respectfully acknowledge the University of Arizona is on the land and territories of Indigenous peoples. Today, Arizona is home to 22 federally recognized tribes, with Tucson being home to the O'odham and the Yaqui. Committed to diversity and inclusion, the University strives to build sustainable relationships with sovereign Native Nations and Indigenous communities through education offerings, partnerships, and community service.

Welcome

- SWTRC region
- Fellow HRSA Grantees
- All other participants

The **Arizona Department of Health Services, the Arizona Telemedicine Program,** and **the Southwest Telehealth Resource Center** welcome you to this free webinar series.

The practice & deliver of healthcare is changing, with an emphasis on **improving quality, safety, efficiency, & access to care**.

Telemedicine can help you achieve these goals!

Webinar Tips & Notes

- When you joined the webinar your phone &/or computer microphone was muted
- Time is reserved at the end for Q&A, please use the **Chat function** to ask questions
- Please fill out the post-webinar survey
- Webinar is being recorded
- Recordings will be posted on the ATP website
    - http://telemedicine.arizona.edu/webinars/previous

Carol Yarbrough

Takeaways from the AHLA Institute on Medicare and Medicaid Payment Issues

Disclaimer

- The opinions expressed in this presentation and on the following slides are solely those of the presenter and not necessarily those of the organizations sponsoring this webinar. The organizations do not guarantee the accuracy or reliability of the information provided herein.

Objectives

- The conference was a hodgepodge of information provided by panelists who were happy to be out of the living room and into the conference room
- The following slides are snips from sessions that I attended and I thank the providers in advance for the liberal borrowing of knowledge shared so generously during the conference

STATS

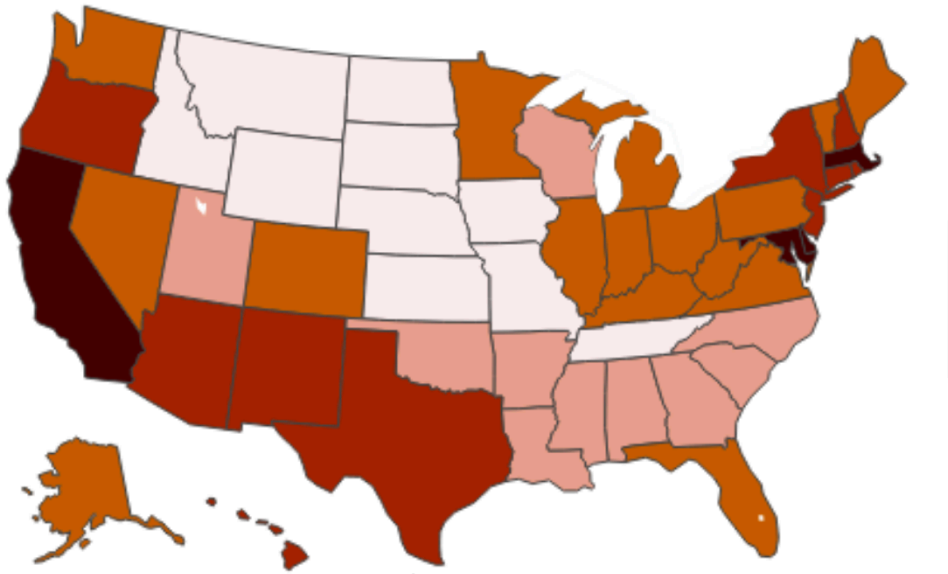
Medicare Telemedicine Snapshot

Medicare Claims and Encounter Data: March 1, 2020 to February 28, 2021, Received by September 9, 2021

28,255,180 Unique Telemedicine Users

53% of Medicare Users

Percentage of Medicare Users with a Telemedicine Service[1] by Geography



Map Scale: Percentage (%)

Rural Areas: **44%**

Urban Areas: **55%**

Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. Please see page 4 and view the methodology document available here.

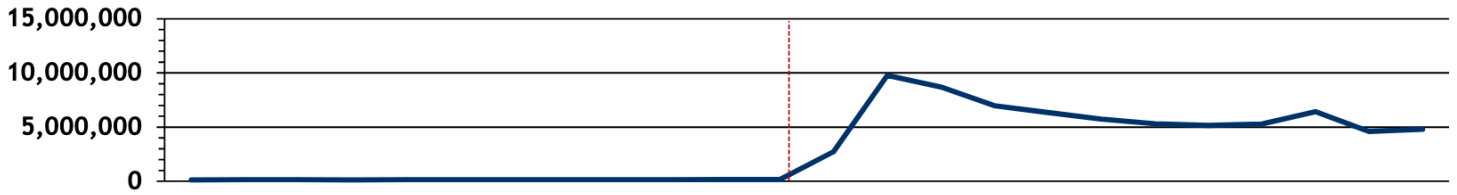
[1]Only beneficiaries with at least one telemedicine-eligible service are included in the denominator.

Medicare Telemedicine Snapshot

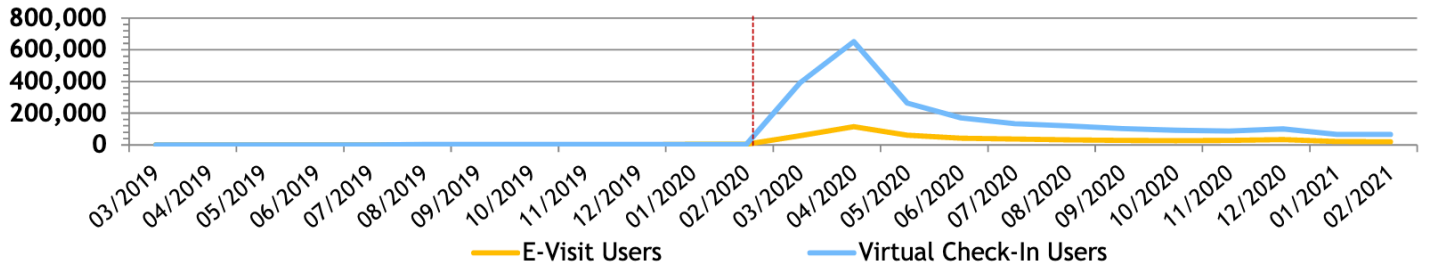
Medicare Claims and Encounter Data: March 1, 2019 to February 28, 2021, Received by September 9, 2021

Telemedicine Users: Pre-Pandemic and Pandemic Period	Total	Telehealth	E-visit[1]	Virtual Check-In
Pre-pandemic (March 1, 2019 - Feb 29, 2020)	**910,490**	892,121	5,220	14,088
Pandemic (March 1, 2020 - Feb 28, 2021)	**28,255,180**	27,691,878	367,467	1,601,033

Two Year Trend - Telehealth



Two Year Trend – E-Visits and Virtual Check-Ins



Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. Please see page 4 and view the methodology document available here.

[1]*Medicare coverage for E-Visits started on January 1, 2020.*

REASSIGNMENT

Inter-Jurisdictional Reassignments – New Revision

- 10.3.1.4.3 – Additional Form CMS-855R Policies and Processing Alternatives
  (Rev. 11168; Issued:12-22-21; Effective:12-31-21; Implementation:01-24-22)
  A. Inter-Jurisdictional Reassignments

  2. The reassignor need not – pursuant to the reassignment - enroll in the reassignee's contractor jurisdiction nor be licensed/authorized to practice in the reassignee's state. If the reassignor will be performing services within the reassignee's state, the reassignor must enroll with the contractor for (and be licensed/authorized to practice in) that state.

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/pim83c10.pdf

In plain language

Dr. White Coat is the reassignor. He lives in Arizona, and is enrolled with Jurisdiction F Part B, Noridian, the Medicare Administrative Contractor for Arizona. He wants to provide telehealth services for Jones Clinic in California.

Dr. White Coat then obtained his license in California.

Then he reassigned his enrollment to the reassignee, Jones Clinic, located in California, which is Jurisdiction E Part B, also Noridian.

In the Practice Location Information of its Form CMS-855B, Jones Clinic will select the practice location type as “Other health care facility” and specify “Telemedicine location”. Dr. White Coat’s address is listed on the 855B, but the Practice Location is still Jones Clinic on the CMS 1500.

Used to be in Chapter 15

- 15.5.20.1 – Inter-Jurisdictional Reassignments (Rev. 636, Issued: 02-04-16, Effective: 03-04-16- Implementation: 03-04-16)
  - If you do a side-by-side comparison, you can see a few changes in semantics and special call-out to Additional Form 855R

FEDERATION OF STATE MEDICAL BOARDS

U.S. States and Territories Modifying Licensure Requirements for Physicians in Response to COVID-19

(Out-of-state physicians in-person practice; license renewals)

Last Updated: March 31, 2022

States with Waivers: 20 + USVI
States with Waivers, not allowing new applications: 0
States without Waivers (or closed waivers): 30 + DC + GU
States allowing OOS physicians long-term or permanent privileges: 7 + DC + CNMI + PR

On January 28, 2021, HHS announced the fifth amendment to the Public Readiness and Emergency Preparedness (PREP) Act, **authorizing any healthcare provider who is licensed or certified in a state to prescribe, dispense, or administer COVID-19 vaccines in any other state or U.S. territory**. The amendment also authorizes any physician, registered nurse, or practical nurse whose license or certification expired within the past five years to partake in the immunization effort, but first must complete a CDC Vaccine Training and an on-site observation period by a currently practicing healthcare professional.

https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirementscovid-19.pdf

What is in effect in Arizona?

- Status – Active, for those already with emergency temporary licenses, until December 31, 2022 (see above). In addition, Arizona has universal license reciprocity, meaning that Arizona's licensing boards will recognize out-of-state occupational licenses for people who have been licensed in their profession for at least one year, are in good standing in all states where they are licensed, pay applicable Arizona fees, and meet all residency, testing, and background check requirements. (Article)

OIG AND COMPLIANCE CONSIDERATIONS

What can go wrong

- Licensure Issues
  - Provider confusion before COVID
  - State changes during the COVID PHE
    - Confusing about the CMS waiver of licensure and the state positon on licensure
  - Ongoing changes
    - Temporary or emergency licensure
    - As of 1/27/22
      - There are 26 states plus the USVI with waivers in place
      - 24 states and DC don't have or have closed waivers
      - 6 states, DC, CNMI, and PR allow out-of-state physicians long-term or permanent privileges
      - Source: https://www.fsmb.org/siteassets/advocacy/pdf/state-emergency-declarations-licensures-requirementscovid-19.pdf
  - Post COVID
    - CMS could adopt the licensure requirement changes it waived during the PHE
    - This would not necessarily impact the state licensure requirements regarding practicing medicine in the state.

What are the enforcement hotspots?

- OIG has focused on telehealth and telehealth fraud with the broad expansion during the PHE
- OCR continues the exercise of enforcement discretion related to the form and format to tools used to conduct telehealth visits
  - Not sure how that will change once the PHE is lifted.
- September 2020 OIG announced a taken down of 345 defendants alleged to have submitted $4.5 billion in false or fraudulent telehealth claims.
  - Pharmacies
  - DME
  - Providers
  - Genetic testing labs

Medicare Telehealth Today

	Pre-COVID-19	During COVID-19
All Providers Eligible to Bill	Only certain distant site practitioners were allowed to bill for Medicare telehealth services.	CMS expanded the list of practitioners who can bill for Medicare telehealth services to any professional eligible to bill Medicare for their professional services, including (1) physical therapists, (2) occupational therapists, and (3) speech language pathologists.
Waived Geographic and Originating Site Location	The patient had to be in specifically designated geographic regions and specifically enumerated locations (originating sites) to be eligible for telehealth, which did not generally include the patient's home.	The patient can receive telehealth services anywhere, including their home
Services Eligible for Telehealth	CMS had a narrow list of services (CPT codes) that could be billed via telehealth.	CMS dramatically expanded the list of services (CPT) codes that could be billed via telehealth.
Technology/Modality Used for Telehealth	CMS required a "interactive audio and video telecommunications systems" that permits "real-time communication" between the patient and distant site provider—did not include telephones.	CMS allows providers to use smartphones with video capabilities (e.g., zoom, facetime, etc.). CMS also allows providers to furnish certain E/M services via *audio-only* technologies.
Established v. New Patients	Certain telehealth services could only be provided to "established patients".	CMS allows telehealth services to be furnished to established and new patients.
Payment Parity with In-Person Services	All telehealth services were paid at the "facility rate", which was generally lower than what physicians would be paid for in-person services.	CMS pays telehealth services at same rates as furnished in-person, including audio-only E/M services.

What does Facility versus Parity mean?

- G0463 – the facility fee associated with clinic visits
  - OPPS sets reimb rate at $121.35
- Typically paired with Pro Fee CPTs 99202-99215
- After the PHE, the facility fee will no longer be reimbursed
  - Not even during the Consolidated Appropriations Act of 2022 “151” days’ duration of extended telehealth waivers

Geographic and Site Limitations

- Most of the benefits providers and patients cite for telehealth stem from being able to use telehealth in the home

- **The Medicare statute plainly limits telehealth services to designated rural regions and originating sites that do not generally include the patient's home**
  - Statutory exception for substance use disorder services and mental health services
  - Congress would need to amend the statute

Existing Patient Limitations

- Telehealth during the PHE has expanded providers' reach by allowing them to serve *new* patients at a distance
- Requiring that providers have an "established" relationship with patients before furnishing telehealth imposes obvious limitations on providers' ability to maximize investments in telehealth
- **The statute does not require that CMS impose an in-person requirement for telehealth services**
  - Exception for mental health services furnished in the home—the statute requires an in-person meeting within 6 months *prior* to the first telehealth service

RPM AND RTM OPPS DISCOVERIES

RPM Pro Fees – Non-Facility

Addendum B – Relative Value Units and Related Information Used in CY 2022 Final Rule										
CPT[1]/ HCPCS	Mod	Status	Not Used for Medicare Payment	Description	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]
99453		A		Rem mntr physiol param setup	0.00	0.54	NA	0.01	0.55	NA
99454		A		Rem mntr physiol param dev	0.00	1.60	NA	0.01	1.61	NA
99455		R		Work related disability exam	0.00	0.00	0.00	0.00	0.00	0.00
99457		A		Rem physiol mntr 1st 20 min	0.61	0.80	0.25	0.04	1.45	0.90
99458		A		Rem physiol mntr ea addl 20	0.61	0.53	0.25	0.04	1.18	0.90

CPT #	Description	Who	RVUs (Non-facility) 2021	Payment 2021	RVUs (Non-facility) 2022	Payment 2022
99453	Initial set-up and patient education on use of equipment	Clinical staff	0.55	$19.19	0.55	$19.03
99454	Device(s) supply with daily recording and transmission of data for each 30 days	Clinical Staff	1.81	$63.16	1.61	$55.72
99457	20 minutes a month of monitoring and interactive communication; includes phone, text and email	MD, NP and clinical staff	1.46	$50.94	1.45	$50.18
99458	Add-on code for an additional 20 minutes of RPM services in a given month	MD, NP and clinical staff	1.18	$41.17	1.18	$40.83
99091	Collection and interpretation of remote physiologic data by qualified healthcare professional	QHCP	1.10	$56.88	1.10	$56.41

RPM Facility Fees

	Addendum B.- OPPS Payment by HCPCS Code for CY 2022						
HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
99453	Rem mntr physiol param setup	V	5012	1.4416	$121.35	.	$24.27
99454	Rem mntr physiol param dev	Q1	5741	0.4518	$38.03	.	$7.61
99457	Rem physiol mntr 1st 20 min	B					
99458	Rem physiol mntr ea addl 20	B					

- Recall the Reimb for Pro Fee:
  - Non-Facility Payment of 99453: $19.19
  - Non-Facility payment of 99454: $50.18
- Payment Diff
  - Non-Facility Payment of 99453: $102.16
  - Non-Facility payment of 99454: -$12.18

RTM Pro Fees – Non-Facility

Addendum B – Relative Value Units and Related Information Used in CY 2022 Final Rule

CPT[1]/ HCPCS	Mod	Status	Not Used for Medicare Payment	Description	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]
98975		A		Rem ther mntr 1st setup&edu	0.00	0.54	NA	0.02	0.56	NA
98976		A		Rem ther mntr dev sply resp	0.00	1.60	NA	0.01	1.61	NA
98977		A		Rem ther mntr dv sply mscskl	0.00	1.60	NA	0.01	1.61	NA
98980		A		Rem ther mntr 1st 20 min	0.62	0.79	0.25	0.04	1.45	0.91
98981		A		Rem ther mntr ea addl 20 min	0.61	0.52	0.25	0.05	1.18	0.91
99000		B		Specimen handling office-lab	0.00	0.00	0.00	0.00	0.00	0.00
99001		B		Specimen handling pt-lab	0.00	0.00	0.00	0.00	0.00	0.00
99002		B		Device handling phys/qhp	0.00	0.00	0.00	0.00	0.00	0.00
99024		B		Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00
99026		N		In-hospital on-call service	0.00	0.00	0.00	0.00	0.00	0.00

Non-Facility RTM Reimb (cont.)

CPT #	Description	Who	RVUs (Non-facility) 2022	Payment 2022
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	Clinical staff	0.56	$19.38

Non-Facility RTM Reimb (cont.)

CPT #	Description	Who	RVUs (Non-facility) 2022	Payment 2022
98976	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days)	Clinical Staff	1.61	$55.72
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days)	Clinical Staff	1.61	$55.72

RTM Facility Fees

1		Addendum B.- OPPS Payment by HCPCS Code for CY 2022						
4	HCPCS Code	Short Descriptor	SI	APC	Relative Weight	Payment Rate	National Unadjusted Copayment	Minimum Unadjusted Copayment
10638	98975	Rem ther mntr 1st setup&edu	V	5012	1.4416	$121.35	.	$24.27
10639	98976	Rem ther mntr dev sply resp	Q1	5741	0.4518	$38.03	.	$7.61
10640	98977	Rem ther mntr dv sply mscskl	Q1	5741	0.4518	$38.03	.	$7.61
10641	98980	Rem ther mntr 1st 20 min	B					
10642	98981	Rem ther mntr ea addl 20 min	B					

- Recall the Reimb for Pro Fee:
  - Non-Facility Payment of 98975: $19.38
  - Non-Facility payment of 98976: $55.72
- Payment Diff
  - Non-Facility Payment of 98975: $102.16
  - Non-Facility payment of 98976: -$17.69

Status Indicator Codes

- V - Medical visit to clinic or emergency department.
- Q1 - STV-Packaged codes.
  - Paid under OPPS; Addendum B displays APC assignments when services are separately payable.
  - Packaged APC payment if billed on same date of service as a HCPCS assigned status indicator "S", "T", "V".
  - In all other circumstances, payment is made through a separate APC payment.

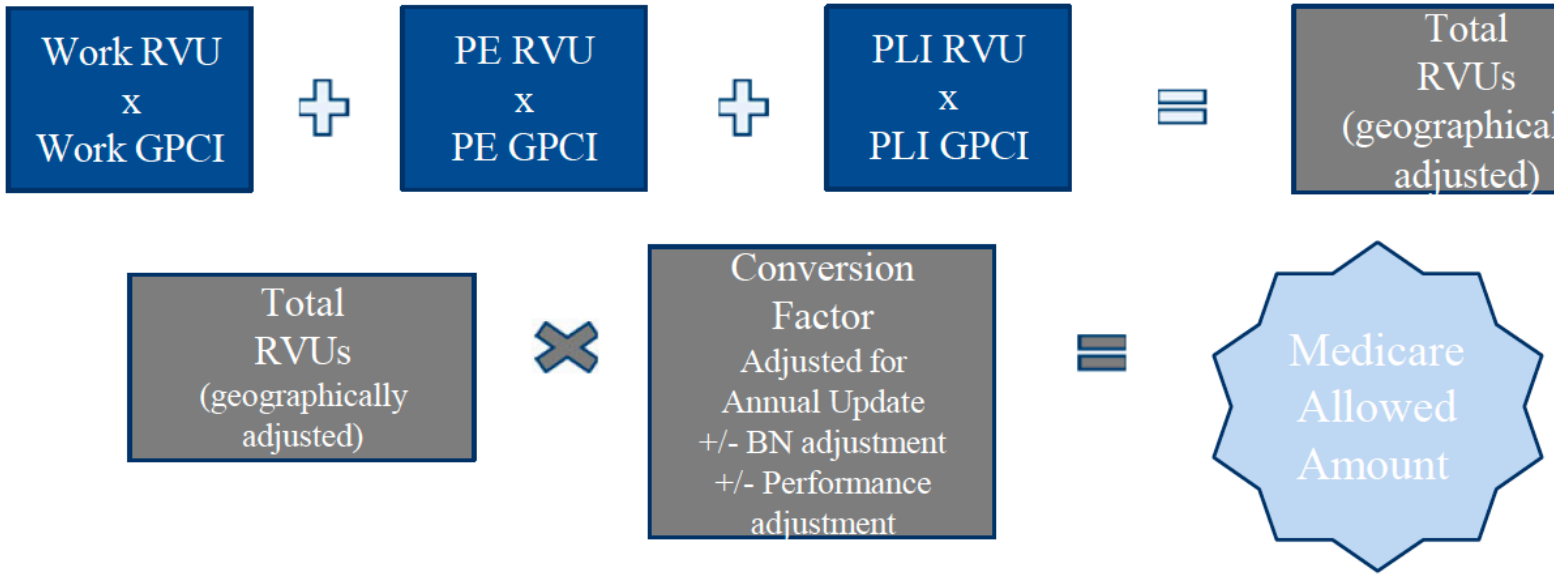
MPFS CONSIDERATIONS

Speaking of the MPFS

The Medicare Physician Fee Schedule ("MPFS")

- Since 1992, Medicare has paid physicians and other practitioners based on a fee schedule
- The MPFS is updated annually and includes a pre-determined rate by CPT code for all services
- Applies to Medicare services furnished by physicians, dentists, podiatrists, optometrists, chiropractors, nurse practitioners, physician assistants, certified nurse midwifes, clinical nurse social workers, therapists and other nonphysician practitioners

How fees are calculated



- None of these numbers takes inflation into account

Work = Physician time & intensity in providing the service
Practice Expense (PE) = Overhead costs for providing the service
PLI = Professional liability insurance expenses associated with the service
GPCI = Geographic Practice Cost Indices
BN = Budget neutrality

THE PHE AND THE CAA OF 2022

The PHE: What stays permanently

- Medicare reimbursement for eligible telehealth services when the patient is located in a geographically rural area AND in an eligible originating site (i.e., in most cases not the home).
- Medicare reimbursement for mental health telehealth services (including audio-only services in some cases), provided that there is an in-person visit within the first six months of an initial telehealth visit and every 12 months thereafter. Implementation of this in-person requirement is delayed for 151 days.
- Medicare reimbursement to federally qualified health centers and rural health clinics, although it will no longer be billed the same or for 'telehealth' specifically. CMS has redefined a 'mental health visit' to now include encounters furnished through interactive, real-time telecommunications technology (which will include audio-only delivery in some cases) for a mental health disorder.

What stays on a temporary basis (151 days), but will go away afterward:

- Medicare reimbursement for telehealth services provided to patients at home.
- Medicare reimbursement for an expanded list of eligible providers, such as occupational therapists, physical therapists, speech language pathologists and audiologists.
- Medicare coverage of audio-only telehealth for non-mental health visits.
- Reimbursement of FQHCs and RHCs as distant site telehealth providers for non-mental health services. As noted above, FQHCs and RHCs will continue to be reimbursed for 'interactive, real-time telecommunications technology' for a mental health disorder.

What goes away immediately:

- Reimbursement of some Medicare telehealth services will expire when the PHE ends (such as group psychotherapy and phone E/M codes 99441-99443) , others have been extended through the end of 2023 (such as some occupational and physical therapy service codes, emergency department visit, and nursing facility discharge day). See CMS telehealth service list for exact codes.
- During the emergency, providers were able to prescribe controlled substances without an in-person examination. This flexibility will expire with the end of the PHE, requiring providers to adhere to strict rules. In most cases, this will require a patient be located in a doctor office or hospital registered with the DEA to be prescribed a controlled substance via telehealth.

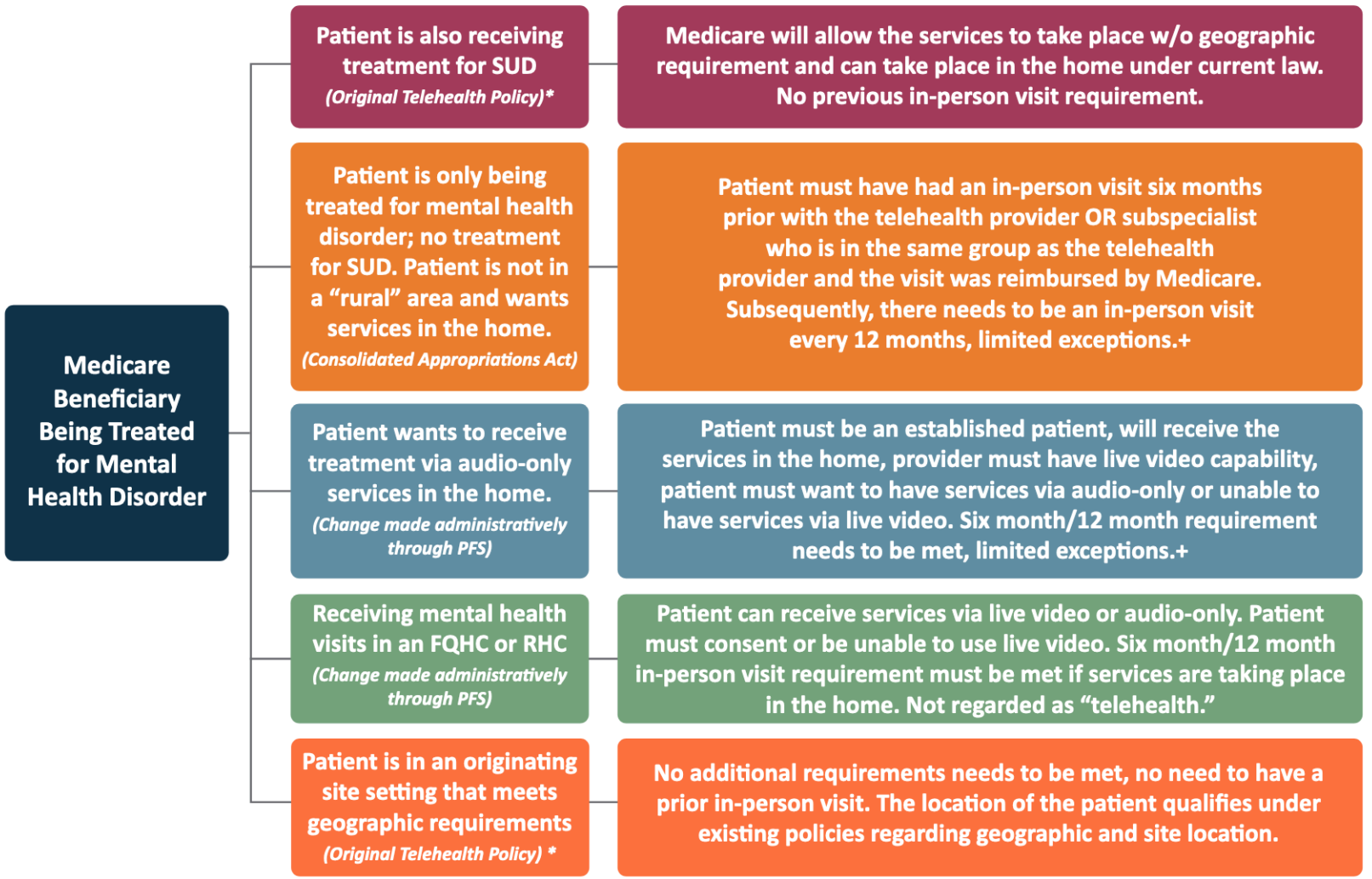
The Telehealth Codes - Example

		LIST OF MEDICARE TELEHEALTH SERVICES effective January 1, 2022 - updated January 5, 2022	
Code	Short Descriptor	Status	Can Audio-only Interaction Meet the Requirements?
99202	Office/outpatient visit new		
99203	Office/outpatient visit new		
99204	Office/outpatient visit new		
99205	Office/outpatient visit new		
99211	Office/outpatient visit est		
99212	Office/outpatient visit est		
99213	Office/outpatient visit est		
99214	Office/outpatient visit est		
99215	Office/outpatient visit est		
99217	Observation care discharge	Available up Through December 31, 2023	
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic	
99224	Subsequent observation care	Available up Through December 31, 2023	
99225	Subsequent observation care	Available up Through December 31, 2023	
99226	Subsequent observation care	Available up Through December 31, 2023	

What's Up in the Air?

- During the COVID public health emergency, HHS Office for Civil Rights (OCR)applied enforcement discretion to telehealth providers, allowing them to utilize any non-public facing remote communication product, even if they don't fully comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since this decision was made administratively, OCR has the ability to keep this policy OR allow it to expire when the PHE ends.
- Many state-based policies will vary depending on the end of a given state's public health emergency and/or state of emergency and may or may not be tied to the end of the federal public health emergency. Policies that fall under state jurisdiction include Medicaid reimbursement, private payer insurance reimbursement and waivers that allowed out-of-state licensed providers to practice within a given state due to the emergency circumstances. Visit CCHP's COVID policy tracker for more information on state-based policies.

CY 2022 MEDICARE REIMBURSEMENT FOR MENTAL HEALTH SERVICES VIA TELEHEALTH & AUDIO-ONLY



TELEHEALTH POLICY IMPACTS OF THE 2022 CONSOLIDATED APPROPRIATIONS ACT

Below is a quick reference regarding the major impacts on federal telehealth policy on Medicare. For the most part, the policies focus on the temporary changes that were made to Medicare telehealth policy in response to COVID-19.

MEDICARE		
ISSUE	**CHANGE MADE BY BUDGET BILL**	**DIFFERENCE FROM CURRENT WAIVER**
Patient Location – Geographic	Extension of waiver on the geographic location of patient requirement to continue an additional 151 days after the Public Health Emergency (PHE) is declared over.	No difference from current COVID-19 temporary waiver.
Patient Location – Site	Extension of waiver on the site location of patient requirement to continue an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.
Eligible Providers	Allow FQHCs, RHCs, PTs, OTs, Speech-Language Pathologists and Audiologists to continue to be reimbursed for services delivered via telehealth an additional 151 days after the PHE is declared over.	Under the current COVID-19 waivers, the category of providers is all eligible Medicare providers.
Audio-Only	Extension of waiver on the use of audio-only as a modality to continue an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.
Recertification of eligibility for hospice care	Extension of waiver on the use of telehealth to continue to be used an additional 151 days after the PHE is declared over.	No difference from current COVID-19 temporary waiver.

OTHER TELEHEALTH POLICY ISSUE	
ISSUE	**CHANGE MADE BY BUDGET BILL**
In post-PHE environment, requirement of an in-person visit before a mental health visit via telehealth takes place when not meeting geographic and site requirements imposed on telehealth for Medicare program (Includes FQHCs, RHCs and audio-only requirement)	Delay requirement 151 days after the PHE is declared over.
Concern over fraud/waste and utilization	MedPAC will do a report for Congress on utilization and other issues in Medicare/OIG will do a report on fraud and waste. Due to Congress June 2023

MARCH 15, 2022

This fact sheet is made possible by Grant #U6743496 from the Office for the Advancement of Telehealth, Health Resources and Services Administration, DHHS.

PHE RENEWED!!

- This means – new end date is July 15, 2022
  - If not renewed on July 15, then the 151 days per the CAA will take us through Dec 15 or so.

- https://aspr.hhs.gov/legal/PHE/Pages/COVID19-12Apr2022.aspx

Resources and Thanks

- https://www.cms.gov/sites/default/files/2021-12/Medicare%20COVID-19%20Telemedicine%20Snapshot%2020211203_0.pdf
- https://aspe.hhs.gov/
- https://www.cchpca.org/2022/03/2022BillingGuidefinal.pdf

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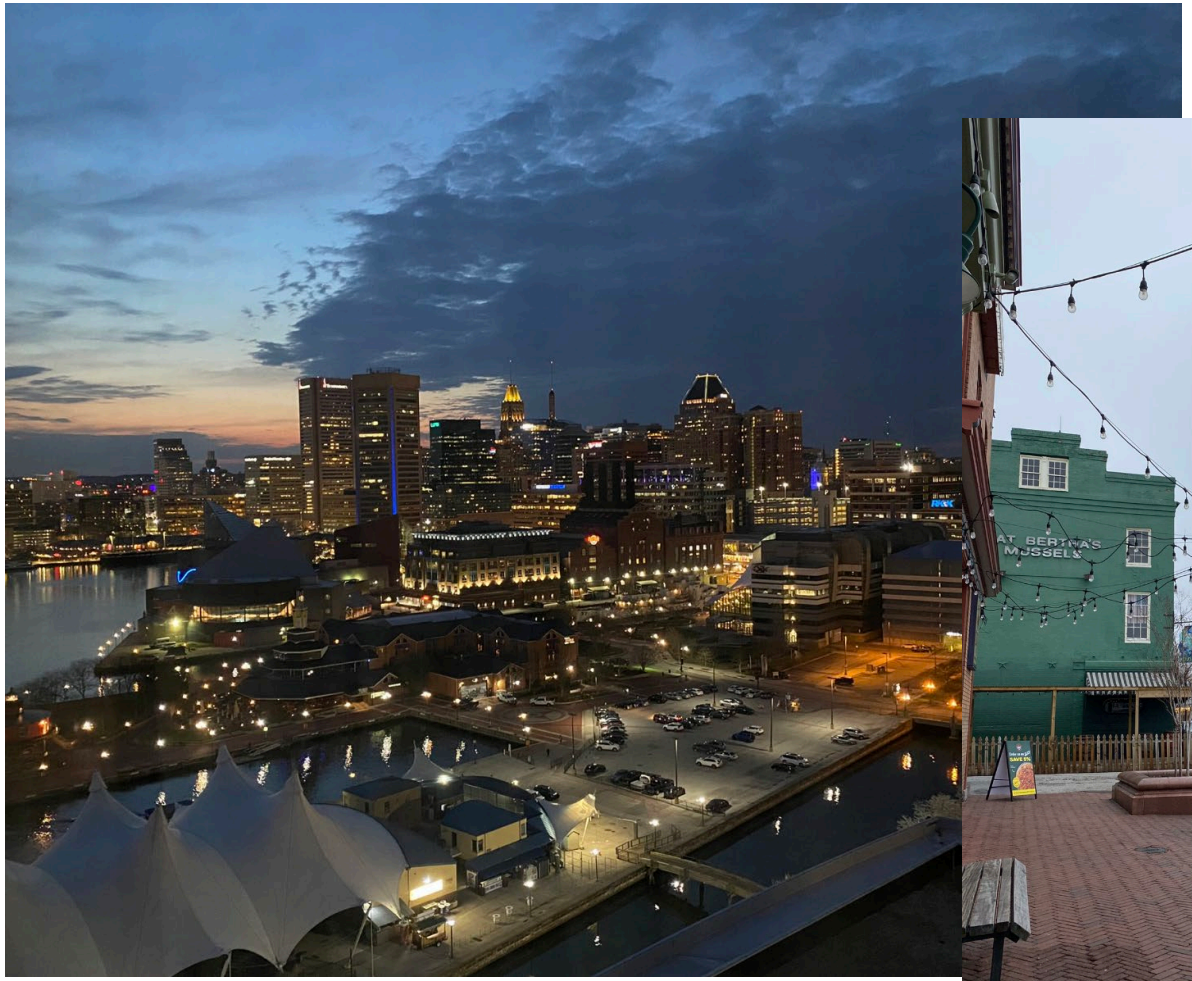
  - Louise M. Joy, Joy & Young
  - Jeanne L. Vance, Weintraub Tobin
  - Mei Kwong, Executive Director, Center for Connected Health Policy

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QUESTIONS

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Please check our websites for upcoming webinars and events

http://www.telemedicine.arizona

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Your opinion is valuable to us.
Please participate in this brief survey:

https://www.surveymonkey.com/r/2022Webinar-SWTRC-ATP

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