RHC BRIEFS

MAY 2020

RHC TRAINING OPPORTUNITIES

Virtual Office Hours: Consent & Documentation

Date: May 21, 2020 Time: 1:30 pm - 2:30 pm ET

Presented by: Luke Worley, BA, Resource Development Coordinator of IRHA & Upper Midwest Telehealth Resource Center (UMTRC) for telehealth resources for IN, IL, OH and MI.

- What constitutes patient consent?
- How do I document a telemedicine visit?
- How do I take a patient's vitals when they are at home?

Register Here

RHC HIPAA and Privacy Webinar

June 3rd, 2pm- 3 pm ET

Presented by Stacy Cook, JD, Partner, Barnes & Thornburg LLP

- Identify the situations where the law does not give a parent the right to her child's medical information.
- Ensure HIPAA compliance when disclosing medical information to family members.
- List the individuals authorized under HIPAA and Indiana law to receive medical information of a deceased patient.

Stacy Cook is a partner in the Healthcare Department of Barnes & Thornburg LLP. Stacy brings her experience as a former litigator, regulator and in-house counsel to provide a unique perspective in representing clients. She concentrates her practice on healthcare regulatory issues and privacy and security matters, including HIPAA. Stacy guides clients through the various aspects of HIPAA compliance, including drafting policies and

procedures, drafting and negotiating business associate agreements, handling large and small breaches, and defending clients under investigation by the Office for Civil Rights. **REGISTER HERE**

RHC Program Evaluation & Mock Survey Webinar

late June 2-3:30 pm ET Presented by Joanie Perkins

IRHA Annual Conference

November 17-18, French Lick Indiana

Changes to Codes for Telephone and Virtual Patient Communications

In the past couple of months, there has been an abundance of messages about how to code for some of the new patient communication options during the Public Health Emergency (PHE). In some cases, directions from CMS and the MACs have differed. One strategy to mitigate some frustrations is to run a trial claim with your MAC before filing a batch of similar claims.

The announcement that telephone visits were permissible was announced March 30, 2020 and retroactively effective for March 1, 2020. These were called Virtual Check-Ins and issued a new code of G0071 and paid at $24.76. The next month, April 30th CMS posted the updated version of SE20016, with red font, that announced many changes to the interim telehealth services, particularly the use of a traditional (audio only) telephone that providers could communicate with their rural patients. Unfortunately, many Hoosiers still do not have access to cell phone signals from their home, like me! RHCs across the country advocated for this means of delivering safe access to health care to their rural residents who do not have internet on account of their address or their choice. Albeit, this was a critical need and CMS responded! The visits could be billed as such retroactively from March 6, 2020. During the COVID-19 PHE, RHCs can furnish any telehealth service that is approved as a Medicare telehealth service under the PFS. (See https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes .) This new telephone service is described as audio-only telephone evaluation and management (E/M) services that previously was coded as CPT 99441, 99442, and 99443. **RHCs** can furnish and bill for these services **using HCPCS code G2025**. To bill for these services, at least 5 minutes of telephone E/M service by a physician or other qualified health care professional who may report E/M services must be provided to an established patient, parent, or guardian. These services cannot be billed if they originate from a related E/M service provided within the previous 7 days or lead to an E/M service or procedure within the next 24 hours or soonest available appointment.

The Interim Claims for Distant Telehealth Services from Jan. 27th through June 30th are coded as:

Revenue Code	HCPCS Code	Modifiers
0521 (SNF 0524 part A or 0525 non part A)	G2025	CG (required) 95 (optional)

Interim RHC Claims for Telehealth Services starting July 1, 2020

Revenue Code	HCPCS Code	Modifiers
0521 (SNF 0524 part A or 0525 non part A)	G2025	CG (required) 95 (optional)

The most recent webinars covering COVID 19 RHC billing are still available to view:

May 8, 2020 - **UMTRC Webinar: Telehealth/Telemedicine billing with current RHC rules/regulations on Medicare billing rules**
Presenter: Mark R. Lynn, CRHCP, CPA
RHC Consultant, Healthcare Business Specialists, LLC
Recording Slides

May 5, 2020 - **RHC Billing including Special COVID 19 Coding**

Presenter: Sharon Shover, CPC, CEMC, Indiana Hospital Association

Recording **Slides**

DECISION TREE

Sharon Shover referenced a **DECISION TREE** in her presentation. Here is the link to it and it is packed with valuable information. There is also a lot of good coding information for Medicaid and commercial payers. This was put together on April 30th, so it only speaks of the telephone only service as virtual check-in, G0071. As discussed previously, the evening of April 30th, CMS gave interim permission to include telephone only as a telehealth/telemedicine service. (G2025)

https://www.ismanet.org/pdf/TelemedicineDecisionTreeNEW-FQHC4-30-2020.pdf

The last page has a link to slides from an AMA presentation designed for non-RHC primary care. There is good information; however, keep the special RHC coding rules in mind as you review it. (G0071, G2025, POS, Revenue codes)

G0071 is still a valid code: During the PHE period, the RHC can use G0071 for e-check-ins and portal communication, e.g. EMR messages between patient and provider. These services must last at least 5

minutes over a 7 day period. Medical discussion or remote evaluation of a condition must not be related to an RHC service within the previous 7 days and does not lead to an RHC visit within the next 24 hours. Use revenue code 0521 for Medicare patient. Payment is $24.76. For private/commercial insurance bill the appropriate CPT codes attached to the time spent with the patient, e.g. 99421, 94422, 99443.

Telehealth January 27-June 30: Medicare telehealth visits will initially be reimbursed at the clinic's AIR. Beginning July 1, the MACs will automatically reprocess the claims and adjust the reimbursement to $92.04. That means Independent clinics will receive more, and PB clinics will have to return the difference. Claims can be held until July 1, if you do not want to go through reprocessing. For examples and a more detailed explanation of the adjustment, view Mark Lynn's video or slides on the previous page.

What services does Medicare approve for virtual visits during this public health emergency? Find a list of the approved Telehealth Services here.

Copays: CS is the code for waiving cost sharing. CMS requires cost sharing for telehealth services; however, during the public health emergency, providers can choose to waive or reduce the cost share for telehealth services without penalty or sanctions. CMS will not pay the difference in this instance; however, they will if COVID-19 related.

Under the Families First legislation all health plans are required to provide coverage of COVID19 testing without cost sharing to patients. Do not charge copays or co-insurance for these services. Do not collect any money for self-pay patients related to COVID-19 testing or services. Federal funding will be available to cover these expenses.

As of March 1, Medicare will pay at 100% for a visit that includes COVID-19 testing. Use of modifier CS notifies CMS that the copay is waived for the COVID related visit. This seems to be viewed more narrowly by some of the MACs. Some interpret this as a COVID related visit, while others require testing to be ordered during the visit.

The WPS and Palmetto websites posted the April 7th MLN announcement, "Cost-sharing does not apply for COVID-19 testing-related services, which are medical visits that:

- Are furnished between March 18, 2020 and the end of the Public Health Emergency (PHE)
- Result in an order for or administration of a COVID-19 test
- Related to furnishing or administering such a test or to the evaluation of an individual for purposes of determining the need for such a test."

Visit www.coronavirus.gov to review the work the Task Force is doing in response to COVID-19, For a complete and updated list of CMS actions, and other information specific to CMS, please visit the Current Emergencies Website.

Indiana Medicaid also uses the CS modifier for cost-sharing for specified COVID-19 testing-related services that result in an order for or administration of a COVID-19 test. April 7, 2020 *BT202038*

The Difference Between Tests for COVID-19 (Coronavirus)

1. COVID-19 Molecular (Swab) Test

This test uses a long swab to collect material, including physical pieces of coronavirus, from the back of the nose where it meets the throat. A positive result indicates that viral genetic material is present, but it does not indicate that bacterial or other infections also are present. A negative result indicates that the SARS-CoV2 virus that causes the COVID-19 disease was not found. It is possible to have a very low level of the virus in the body with a negative test result.

This test is needed to identify the presence of the SARS-CoV-2 virus that causes the COVID-19 disease.

2. COVID-19 Antibody (Serology) Test

This is a blood test. It is designed to detect antibodies (immunoglobulins, IgG and IgM) against the coronavirus that causes the disease called COVID-19. Antibodies are proteins produced by the immune system in response to an infection and are specific to that particular infection. They are found in the liquid part of blood specimens, which is called serum or plasma, depending on the presence of clotting factors. IgM and IgG may either be ordered together or separately.

Having an antibody test is helpful if:

- Your health care provider believes you may have been exposed to the coronavirus which causes COVID19 based on your current or previous signs and symptoms (e.g., fever, cough, difficulty breathing);
- You live in or have recently traveled to a place where transmission of COVID-19 is known to occur;
- You have been in close contact with an individual suspected of or confirmed to have COVID-19
- You have recovered from COVID-19.

Antibody Test for IgG

This test detects IgG antibodies that develop in most patients within seven to 10 days after symptoms of COVID-19 begin. IgG antibodies remain in the blood after an infection has passed. These antibodies indicate that you may have had COVID-19 in the recent past and have developed antibodies that may protect you from future infection. It is unknown at this point how much protection antibodies might provide against reinfection.

Antibody Test for IgM

This test detects IgM antibodies. IgM is usually the first antibody produced by the immune system when a virus attacks. A positive IgM test indicates that you may have been infected and that your immune system has started responding to the virus. When IgM is detected you may still be infected, or you may have recently recovered from a COVID-19 infection. (source National Jewish Health)

Compliance Issues

Rural Health Clinic Temporary Expansion Waiver CMS is waiving the requirements at 42 CFR §491.5(a)(3)(iii) which require RHCs and FQHCs be independently considered for Medicare approval if services are furnished in more than one permanent location. Due to the current PHE, CMS is temporarily waiving this requirement removing the location restrictions to allow flexibility for existing RHCs/ FQHCs to expand services locations to meet the needs of Medicare beneficiaries. This flexibility includes areas which may be outside of the location requirements 42 CFR §491.5(a)(1) and (2) but will end when the HHS Secretary determines there is no longer a PHE due to COVID-19.

RESOURCES

A Solution for Documenting for Telehealth: WhiteBark's Telehealth Platform

(Submitted by Bryce Wray-Nelson)

We acknowledge how challenging accessing specialty healthcare can be, as well as the strain it can put on the budget. In many cases, unlocking the telehealth "arm" of an EMR can be unimaginable and unsustainable to many healthcare organizations. WhiteBark Telehealth Platform performs in conjunction with your EMR, allowing you to drag and drop PDFs of visit summaries into your online portal, as well as print physical copies for paper charting.

Costs accrued upon implementing the WhiteBark Telehealth Platform are easily recovered within the first quarter of implementation, and will continue to not only expand services in your communities, but also help increase your operating budget.

In rural and low-income areas, healthcare and coverage deserts are becoming frequently normalized. The closure of critical access and rural hospitals continue to put a strain on those providers that remain, and otherwise, individuals increasingly go without proper medical care. With this in mind, we recognize the need to support the community and to assist in access to healthcare and specialty healthcare in a cost-effective manner.

The WhiteBark Telehealth Platform can enhance your delivery of care. Please see below for just a sample of options for service expansion:

- Acute Physical Care
- Addiction Counseling
- Behavioral Care
- Tele-Nutrition Guidance
- Tele-Lactation Services
- Tele-Neurology
- Tele-Dermatology
- Medical Education for Various Comorbidities
- Pharmacological Management
- In-Home Follow-Up Care

The WhiteBark Telehealth Platform will help increase your service line, increase revenue, reduce transportation challenges, and protect your patients. We hope that you will reach out to learn more about telehealth program development and continue to make healthcare accessible in all situations and conditions!

For more information including cost and program implementation, please be sure to reach out to our team today!

Deena Dodd
Director of Business Development
WhiteBark Telehealth Platform
ddodd@indianarha.org
812-478-3919, x228

Bryce Wray-Nelson
Project Coordinator
WhiteBark Telehealth Platform
bwray-nelson@indianarha.org
317-607-3639

Long Term Care Toolkit to combat COVID-19

CMS released a new toolkit developed to aid nursing homes, Governors, states, departments of health, and other agencies who provide oversight and assistance to these facilities, with additional resources to aid in the fight against the coronavirus disease 2019 (COVID-19) pandemic within nursing homes.

IRHA's, Connecting Kids to Coverage-IN program has developed an online scheduler for Indiana Health Insurance Program assistance

Visit: www.indianaruralhealth.org/CKC-IN To find their online scheduler to help uninsured patients schedule an appointment that is convenient for them. Towards the center of the page is a button. Simply click on the **Schedule Appointment** button and complete the information requested. They are able to assist with insurance applications by phone and through HIPPA-compliant and secure electronic technologies. Connecting Kids to Coverage not only assists residents with insurance enrollment, but also SNAP, TANF, or other specified needs.

The Governors Next Steps to Getting Indiana Back on Track

In order to protect our health care system from a surge, the response remains data-driven.

We will follow 4 guiding principles to determine how plans to reopen various sectors of the economy move forward:

First – that the number of hospitalized COVID-19 patients statewide has decreased for 14 days.

Our current data show that, as a state, COVID patient admissions have decreased over the past 2 weeks.

Second- that the state retain its surge capacity for critical care beds and ventilators.
Currently, state-wide ICU bed and vent availability has remained above 40% and 70% respectively for the last 2 weeks. The State is helping businesses with their Personal protective equipment and distributing 300 million dollars to counties, cities and towns via a population-based formula, which is the first installment from the Coronavirus Relief Fund.

Third - is that we can test all Hoosiers who are COVID-19 symptomatic.
To help in the early detection of new cases, the state has partnered with OptumServe to add 50 testing locations in strategically located parts of the state. Hoosier employers, employees, and consumers can have confidence anyone concerned they may be sick due to their symptoms, or having been in contact with someone who is, will have the ability to get tested.

Fourth- is to contact all individuals who test positive for COVID-19 and expand contact tracing.
All Hoosiers who test positive in the future will receive a text, email, and a call from one of the state's over 500 contact tracers currently being onboarded. These tracers will identify other Hoosiers potetially at risk and help provide resources individuals may need.

Given the trends moving in the right direction on all 4 fronts, I am ready to announce the next steps of a 5-stage roadmap that with our collective efforts, can help us reach **the goal of having Indiana back on track by July 4th – Independence Day**. Read the full announcement and details for the 5 stages here.

Indiana Rural Health Association
www.indianaruralhealth.org
Dana Stidham
dstidham@indianarha.org