Michigan Turns to Telehealth

April 6, 2020
Welcome!

• This webinar is being recorded! The recording and the slides will be available on our website.

• Your line is muted – this helps reduce background noise!

• If you have questions, concerns, or issues with webinar logistics please use the Chat Box in Zoom - it is being monitored.
Webinar Agenda

• Welcome and introductions
• Health Fund Overview
• Presentations
  • Upper Midwest Telehealth Resource Center
  • Blue Cross Blue Shield of Michigan
  • Michigan Department of Health and Human Services
• Q&A - Ask questions in the Zoom Q&A Box
OUR MISSION

To improve the health of Michigan residents, with special emphasis on the health and wellness of children and seniors, while reducing the cost of health care.

ANNUAL GIVING $30 million+

PROGRAMS
- Behavioral Health
- Healthy Aging
- Nutrition & Healthy Lifestyles
- Community Health Impact
- Special Projects & Emerging Ideas

CROSS-CUTTING GOALS
- Integrated care
- Workforce development

BEYOND GRANTMAKING
- Convenings
- Policy
- Learning and evaluation
Please be advised that UMTRC only provides guidance on billing issues based on experience, anecdotal information we have heard in the field, and through research. Following our advice does not guarantee payment. We always recommend you check with the payer (or your Medicare Administrative Contractor) to verify UMTRC’s information.

Becky Sanders
Senior Director,
Indiana Rural Health Association

Program Director,
Upper Midwest Telehealth Resource Center

This project is/was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number G22RH30351 under the Telehealth Resource Center Grant Program for $325,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
National Consortium of Telehealth Resource Centers
UMTRC Services

- Virtual Librarians
  - Individual Consultation
  - Technical Assistance
  - Connections with other programs

- Presentations & Trainings
  - Project assessments
  - Updates on reimbursement policy and legislative developments
Telehealth versus Telemedicine

- Sometimes used interchangeably
- Two types of distinctions
  - Telehealth
    - Broader field of distance health activities (CME, etc.)
    - Clinical remote monitoring (usually at home)
    - Education
  - Telemedicine
    - Billable interactive clinical services
Types of Telemedicine

- **Asynchronous**
  - Describes store and forward transmission of medical images or information because the transmission typically occurs in one direction in time
  - *Store-and-forward telemedicine*
    - Pictures, data

- **Synchronous**
  - Describes interactive video connections because the transmission of information in both directions is occurring at exactly the same period
  - *Live and Interactive Telemedicine*
    - HIPAA Compliant, Secure real-time audio AND video
Telehealth is not a service; but a delivery mechanism for health care services

- Live and interactive telehealth services duplicate clinical in-person care
- Some services are made better or possible with telehealth when distance is a barrier
- Reimbursement should be equal to “in-person” care
COVID-19

• 3/6/2020 - HR 6074
  • Coronavirus Preparedness and Response Supplemental Appropriations Act

• 3/17/2020 – CMS’ 1135 waiver takes effect removing rural/originating site restrictions for Medicare Telehealth Reimbursement (per HR 6074)

• 3/23/2020 – CMS Releases 2020 Telehealth Fact Sheet
  • with COVID-19 Information
  • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf?utm_source=Telehealth+Enthusiasts&utm_campaign=2a178f351b-EMAIL_CAMPAIGN_2019_04_19_08_59&utm_medium=email&utm_term=0_ae00b0e89a-2a178f351b-353223937

• 3/27/2020 - HR 748
  • CARES Act

• 3/30/2020 – CCHP Coverage Policies
  • https://www.cchpca.org/resources/covid-19-telehealth-coverage-policies

• 3/31/2020 – Interim Final Rule for Comment
COVID-19

COVID-19 TELEHEALTH TOOLKIT

This toolkit has been created to assist providers with resources for integrating telehealth into their COVID-19 response plan.

more>

ILLINOIS COVID-19 RESOURCES

more>

INDIANA COVID-19 RESOURCES

more>

MICHIGAN COVID-19 RESOURCES

more>
Medicare and state Medicaid programs have relaxed HIPAA rules
  - See UMTRC COVID-19 Resource Page
  - [https://www.umtrc.org/resources/covid-19/](https://www.umtrc.org/resources/covid-19/)
    - MI – should be audio and visual service delivery; telephonic allowed for up to 30 days after the discontinuation of the emergency, or the 1st of the following month

UMTRC still recommends HIPAA compliant technology
Professionals are regulated at the state level (doctors, nurses, counselors, etc.)

- **Medicare**
  - Pays for certain outpatient professional services (CPT codes) for patients accessing care in rural counties and HPSAs in rural census tracts
    - *No regs; only conditions of payment*

- **Medicaid**
  - Telemedicine is “a cost-effective alternative to the more traditional face-to-face way of providing medical care... that states can choose to cover”
    - As of Spring 2019, all 50 States and DC cover live and interactive telemedicine
Medicare Telehealth Reimbursement Requirements

Patient outside of a MSA
Patient in Designated Originating Site
Services within CPT Code Range
Services Delivered by Eligible Practitioners

Waived during the national pandemic

Still True, but expanded!
Updated Areas:

- Otherwise eligible sites in Health Professional Shortage Areas (HPSAs) located in rural census tracts of Metropolitan Statistical Area (MSA) counties will be eligible originating sites.
  - (RUCA codes 4-10, also <35/sq. mi. density)

- Eligibility Lookup Tool

Waived during the national pandemic
Eligible Originating and Distant Sites

Eligible Providers

Telehealth Services by HCPCS/CPT Code

Most basic services usually allowed

Many screening and prevention services allowed

### CY 2019 Medicare Telehealth Services

<table>
<thead>
<tr>
<th>Service</th>
<th>HCPCS/CPT Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth consultations, emergency department or initial inpatient</td>
<td>G0425–G0427</td>
</tr>
<tr>
<td>Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs</td>
<td>G0406–G0408</td>
</tr>
<tr>
<td>Office or other outpatient visits</td>
<td>99201–99215</td>
</tr>
<tr>
<td>Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days</td>
<td>99231–99233</td>
</tr>
<tr>
<td>Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days</td>
<td>99307–99310</td>
</tr>
<tr>
<td>Individual and group kidney disease education services</td>
<td>G0420–G0421</td>
</tr>
<tr>
<td>Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction furnished in the initial year training period to ensure effective injection training</td>
<td>G0108–G0109</td>
</tr>
<tr>
<td>Individual and group health and behavior assessment and intervention</td>
<td>96150–96154</td>
</tr>
<tr>
<td>Individual psychotherapy</td>
<td>90832–90838</td>
</tr>
<tr>
<td>Telehealth Pharmacologic Management</td>
<td>G0459</td>
</tr>
<tr>
<td>Psychiatric diagnostic interview examination</td>
<td>90791–90792</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment</td>
<td>90951, 90952, 90954, 90955, 90957, 90958, 90960, 90961</td>
</tr>
<tr>
<td>End-Stage Renal Disease (ESRD)-related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents</td>
<td>90963</td>
</tr>
</tbody>
</table>
CMS Alert!

Medicare Beneficiaries Expanded Telehealth Benefits During COVID-19 Outbreak

Under the Coronavirus Preparedness and Response Supplemental Appropriations Act and Section 1135 waiver authority, the Centers for Medicare & Medicaid Services (CMS) broadened access to Medicare telehealth services, so beneficiaries can get a wider range of services from their doctors and other clinicians without traveling to a health care facility. On March 6, 2020, Medicare began temporarily paying clinicians to furnish beneficiary telehealth services residing across the entire country.

Before this announcement, Medicare could only pay clinicians for telehealth services, such as routine visits in certain circumstances. For example, the beneficiary getting the services must live in a rural area and travel to a local medical facility to get telehealth services from a doctor in a remote location. In addition, the beneficiary generally could not get telehealth services in their home.

Under this Section 1135 waiver expansion, a range of providers, such as doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers, can offer a specific set of telehealth services. The specific set of services beneficiaries can get include evaluation and management visits (common office visits), mental health counseling, and preventive health screenings. Beneficiaries can get telehealth services in any health care facility including a physician’s office, hospital, nursing home or rural health clinic, as well as from their homes. This change broadens telehealth flexibility without regard to the beneficiary’s diagnosis, because at this critical point it is important to ensure beneficiaries follow CDC guidance including practicing social distancing to reduce the risk of COVID-19 transmission. This change will help prevent vulnerable beneficiaries from unnecessarily entering a health care facility when clinicians can meet their needs remotely.

To read the Fact Sheet on this announcement visit: https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

• Physician and Other Clinicians: CMS Flexibilities to Fight COVID-19

• To enable services to continue while lowering exposure risk, clinicians can now provide the following additional services by telehealth:
  • Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
  • Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217-99220; CPT codes 99224-99226; CPT codes 99234-99236)
  • Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
  • Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
  • Critical Care Services (CPT codes 99291-99292)
  • Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327-99328; CPT codes 99334-99337)
  • Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347-99350)
  • Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468-99473; CPT codes 99475-99476)

• Initial and Continuing Intensive Care Services (CPT code 99477-994780)
• Care Planning for Patients with Cognitive Impairment (CPT code 99483)
• Psychological and Neuropsychological Testing (CPT codes 96130-96133; CPT codes 96136-96139)
• Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
• Radiation Treatment Management Services (CPT codes 77427)
• Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.
- A complete list of all Medicare telehealth services can be found here: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

- **Virtual Check-Ins & E-Visits**
  - Additionally, clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
  - Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
  - A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966-98968; 99441-99443)

- **Remote Patient Monitoring**
  - Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease. For example, remote patient monitoring can be used to monitor a patient’s oxygen saturation levels using pulse oximetry. (CPT codes 99091, 99457-99458, 99473-99474, 99493-99494)

- **Removal of Frequency Limitations on Medicare Telehealth**
  - To better serve the patient population that would otherwise not have access to clinically appropriate in-person treatment, the following services no longer have limitations on the number of times they can be provided by Medicare telehealth:
    - A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);
    - A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
    - Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).
Other Medicare Telehealth and Remote Patient Care

- For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one “hands on” visit per month for the current required clinical examination of the vascular access site.

- For Medicare patients with ESRD, we are exercising enforcement discretion on the following requirement so that clinicians can provide this service via telehealth: individuals must receive a face-to-face visit, without the use of telehealth, at least monthly in the case of the initial 3 months of home dialysis and at least once every 3 consecutive months after the initial 3 months.

- To the extent that a National Coverage Determination (NCD) or Local Coverage Determination (LCD) would otherwise require a face-to-face visit for evaluations and assessments, clinicians would not have to meet those requirements during the public health emergency.

- Beneficiary consent should not interfere with the provision of telehealth services. Annual consent may be obtained at the same time, and not necessarily before, the time that services are furnished.

- Physician visits: CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.
• Medicare Physician Supervision requirements: For services requiring direct supervision by the physician or other practitioner, that physician supervision can be provided virtually using real-time audio/video technology.

• Medicare Physician Supervision and Auxiliary Personnel: The physician can enter into a contractual arrangement that meets the definition of auxiliary personnel at 42 CFR 410.26, including with staff of another provider/supplier type, such as a home health agency (defined under § 1861(o) of the Act) or a qualified home infusion therapy supplier (defined under § 1861(iii)(3)(D)), or entities that furnish ambulance services, that can provide the staff and technology necessary to provide care that would ordinarily be provided incident to a physicians’ service (including services that are allowed to be performed via telehealth). In such instances, the provider/supplier would seek payment for any services provided by auxiliary personnel from the billing practitioner and would not submit claims to Medicare for such services.

• Medicare Physician Supervision requirements: Direct physician supervision is no longer required for non-surgical extended duration therapeutic services provided in hospital outpatient departments and critical access hospitals. Instead, a physician can provide a general level of supervision for these services so that a physician is no longer required to be immediately available in the office suite.

• Physician Services: CMS is waiving 482.12(c)(1-2) and (4), which requires that Medicare patients in the hospital be under the care of a physician. This allows hospitals to use other practitioners, such as physician’s assistant and nurse practitioners, to the fullest extent possible. This waiver should be implemented in accordance with a state’s emergency preparedness or pandemic plan.

• National coverage determinations (NCDs) and Local Coverage Determinations (LCDs): To the extent NCDs and LCDs require a specific practitioner type or physician specialty to furnish or supervise a service, during this public health emergency, the Chief Medical Officer or equivalent of a hospital or facility will have the authority to make those staffing decisions.
3/30/2020

Workforce & Supervision

• **Practitioner Locations:**
  
  • Temporarily waive Medicare and Medicaid’s requirements that physicians and non-physician practitioners be licensed in the state where they are providing services. State requirements will still apply. CMS waives the Medicare requirement that a physician or non-physician practitioner must be licensed in the State in which s/he is practicing for individuals for whom the following four conditions are met: 1) must be enrolled as such in the Medicare program, 2) must possess a valid license to practice in the State which relates to his or her Medicare enrollment, 3) is furnishing services – whether in person or via telehealth – in a State in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity, and 4) is not affirmatively excluded from practice in the State or any other State that is part of the 1135 emergency area. A physician or non-physician practitioner may seek an 1135-based licensure waiver from CMS by contacting the provider enrollment hotline for the Medicare Administrative Contractor that services their geographic area. This waiver does not have the effect of waiving State or local licensure requirements or any requirement specified by the State or a local government as a condition for waiving its licensure requirements.

• **Provider Enrollment:**
  
  • CMS has established toll-free hotlines for physicians, non-physician practitioners and Part A certified providers and suppliers establishing isolation facilities to enroll and receive temporary Medicare billing privileges. CMS is providing the following flexibilities for provider enrollment:
    • Waive certain screening requirements.
    • Postpone all revalidation actions.
    • Allow licensed physicians and other practitioners to bill Medicare for services provided outside of their state of enrollment.
    • Expedite any pending or new applications from providers.
    • Allow practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from your currently enrolled location.
    • Allow opted-out practitioners to terminate their opt-out status early and enroll in Medicare to provide care to more patients.
Stark Law Waivers

National Coverage Determinations and Local Coverage Determinations on Respiratory Related Devised, Oxygen and Oxygen Equipment, Home Infusion Pumps and Home Anticoagulation Therapy

Signature Requirements

Changes to MIPS

Accelerated/Advance Payments

Additional Guidance

The Interim Final Rule and waivers can be found at: https://www.cms.gov/about-cms/emergencypreparedness-response-operations/current-emergencies/coronavirus-waivers

CMS has released guidance to providers related to relaxed reporting requirements for quality reporting programs at:

FQHCs and RHCs

- Pre – COVID-19, Medicare only allowed FQHCs/RHCs to be originating site
  - CARES Bill passed on 03/27 allows them to be distant sites
- IL, IN, MI, and OH Medicaid
  - allow RHCs and FQHCs to be both originating and distant site
- Check out UMTRC or CCHP website for more information
Thank YOU!

Becky Sanders

bsanders@indianarha.org
BCBSM Telehealth Update

Telemedicine
(Virtual Visits)
Telephone
Online Visits

4-6-2020
S. George Kipa, MD, MS
Presentation Overview

TELEHEALTH, ONLINE VISITS, and TELEMEDICINE

Briefly review the BCBSM-PPO 2002-2019 Timeline of TELEHEALTH

BCBSM TELEHEALTH POST COVID CHANGES

The member experience (Nurse-line/Online Visits/Telemedicine)

The provider experience (Ramping up quickly/focus on the patient)

Where to get more information re: BCBSM changes
June 12, 2002

As reported in the August 2003 Record, BCBSM starts paying for Telemedicine per CMS guidelines as of June 2, 2002

Dec 2013

54% of surveyed PGIP practices reported some elements of electronic interaction through portals

Nov 2015 BCBSM Record announces “Online visits”

starting January 2016 – low complexity visits using vendor platform

July 2016 BCBSM PPO Telemedicine Policy enhanced

ORIGINATING SITE ELIMINATED for BCBSM PPO
Participating MDs, DOs, CNPs, and PAs may bill any CPT code with GT modifier for services they provided, within their scope of practice, via telemedicine, for which they were able to meet the CPT code documentation requirements.

*(applied to fully insured BCBSM members with a telehealth benefit)*
The Impact of the COVID Crisis

Telehealth is a lifeline for high risk patients and the health care system during the COVID-19 pandemic.

One local healthcare system has increased telehealth visits from 160 per week to 7000 per week.

The health care delivery system of the future will be permanently changed through digital connectivity.

We believe that through innovation, multidisciplinary collaboration and continuous improvement, it will be greatly improved as a result.
| **Online Visits** | • Patient Initiated  
  • No Modifiers  
  • Procedure Codes:  
    98970, 98971, 98972 Payable to a qualified non-physician only  
    99421, 99422, 99423 Payable to a MD/DO/PA/CNP only  
    G2061, G2062, G2063 Payable to a qualified non-physician only  
  • Payable 1 time in a 7-day cumulative period  
  • Low complexity, straightforward decision making  
  • Audio visual communication |
| **Telephone** | • Patient or Provider initiated  
  • No Modifiers  
  • Procedure Codes:  
    99441, 99442, 99443 Payable to physician or other qualified health care professional  
    98966, 98967, 98968 Payable to qualified non-physician (Place of service 02 not required for PDCM coding) |
| **Telemedicine** | • Provider or Patient Initiated  
  • Any CPT specific to provider’s scope of practice  
  • Audio only or Audio and Visual GT or 95 Modifier required  
  • High complexity encounter, many not be the preferred method in certain clinical scenarios. Example: chronic suicidal ideation or unstable angina. A hosted site is preferred.  
  • Originating site not required |
| **Blue Cross Online Visits (Am-Well)** | • Contracted Procedure Codes: 99422 (Online Visit), 90792 (BH), 90834 (BH) and 99213 (Office Visit) |
| **Applied Behavioral Analysis (ABA)** | ABA codes for the treatment of Autism Spectrum Disorder that are appropriate for telemedicine  
  • 97155, 97156, 97157 |
Below is a chart of the changes we’ve made to date for our fully insured commercial and Medicare business (including HSA qualified plans).

<table>
<thead>
<tr>
<th>Service</th>
<th>Actions taken by Blue Cross</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telehealth services for medical visits</td>
<td>March 16 – Provided select medical telehealth services with no cost share through April 30th</td>
</tr>
<tr>
<td></td>
<td>April 2 – Extended the date to June 30 and expanded telehealth with no cost share to cover additional, most common medical services</td>
</tr>
<tr>
<td>Telehealth services for behavioral health</td>
<td>April 2 – Provide most common behavioral therapy services through telehealth with no copay through June 30th</td>
</tr>
</tbody>
</table>
The expanded list of no cost telehealth services for members includes the most common medical office visits and hospitalization follow-up visits as well as common behavioral health therapy. To make this easier for our providers, we’ve published a list of codes that have no member cost sharing through June 30, 2020.

These changes apply to:
- Blue Cross PPO (commercial)
- BCN HMO\textsuperscript{SM} (commercial)
- Medicare Plus Blue\textsuperscript{SM} PPO
- BCN Advantage\textsuperscript{SM}

Telehealth services that are covered under the Blue Cross and BCN Telemedicine Services Medical Policy that are not listed in the above list of codes, are still covered but will require standard member cost sharing.
Effective April 2, 2020 – June 30, 2020

• Waives member cost-sharing on select telehealth services through June 30
• Expands no cost telehealth services to common behavioral health services for members with BCBSM behavioral health benefits
• Communicates specific telehealth services that have no member cost sharing
• Announces that ALL BCBSM/BCN members – including self-funded groups – now have coverage for telemedicine services (those offered by our network providers); most, but not all members also have access to Blue Cross Online VisitsSM (operated by Amwell)
Where to get more detailed information

• A copy of our *Telemedicine Services Medical Policy* and our telehealth guides are available on our [Coronavirus (COVID-19) information updates for providers](bcbsm.com/coronavirus) webpage. You can find this webpage within *BCBSM Newsletters and Resources* and *BCN Provider Publications and Resources*.

• While the information within our secure provider website is more comprehensive, information is also available on our public website at [bcbsm.com/coronavirus](bcbsm.com/coronavirus). Click on *For Providers*.

• MIBluesperspectives.com provides updated information about the BCBSM response to the COVID-19 Crisis.
BCBSM Announces Telehealth at $0 cost share

- Announced 4/2 and focuses on specific codes BCBSM will cover at $0 cost share for all members
- Effective through June 30
- Established medical policy around telemedicine stands, but member cost share will apply (for codes not on the BCBSM subset of the telehealth code list).

Alert and code specifics can be found through provider portal or at bcbsm.com/coronavirus and then click on the “For Providers” tab.

Telehealth procedure codes

```
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>*00785</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00791</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00702</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00832</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00833</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00834</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00836</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00837</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00838</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00839</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00840</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00845</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00846</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00847</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00951</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00952</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00954</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00955</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00957</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00958</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00960</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00961</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00963</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00964</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00965</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00966</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00967</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00968</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00969</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00970</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00911</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00912</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00213</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00214</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00215</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00231</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00232</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00233</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00307</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00310</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00354</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00355</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00356</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00357</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00406</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00407</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00408</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00425</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00426</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00427</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00459</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00508</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*00509</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*02011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*02012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09866</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09867</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09868</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09870</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09871</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09872</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09441</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09442</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09443</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*09804</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0270</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0290</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0290</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0438</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0439</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0442</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0443</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0444</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0445</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0446</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0447</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0208</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0208</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*0208</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Also covered by Blue Cross Online Visits™,

+CPT codes, descriptions and two-digit numeric modifiers only are copyright 2019 American Medical Association. All rights reserved.
Here are two places providers can go to find information from BCBSM on COVID-19:

**Provider Portal (not public)**

- Click here to get here

**bcbsm.com/coronavirus (public)**

- Click here to get here
Key Points

• In 2016, BCBSM launched an innovative medical policy that enabled services to be rendered via telehealth as long as it was appropriate for the encounter and provider scope. This medical policy remains fundamentally in-tact today.

• With the outbreak of COVID-19, BCBSM has applied a benefit policy to encourage members to seek care via telehealth by removing cost share for the most common office visit and hospitalization follow-ups; along with the most common behavioral health therapy services.

• BCBSM continues to refine the benefit policy to continue to encourage members to seek care via telehealth.
What We Are Doing Today - Telemedicine Services

• **For all commercial and Medicare advantage members,** we are strengthening our $0 telehealth cost share offering by including most common office visits, consultations, and hospital discharge that can now be done via telehealth.

• **For groups that have a BCBSM behavioral health benefit,** we are also adding the most common behavioral health therapy services that can be done via telehealth at $0 cost share.

• This applies to our entire PPO and HMO network providers, in and out of the state of Michigan,

• **$0 cost share telehealth services are now available through June 30**
One thing is certain
Tomorrow will be different from Today
Presentation Overview

• High-Level Overview of the Department’s Response to COVID-19

• Overview of Medicaid Telemedicine

• Overview of Recent Medicaid Policy Bulletins
  • MSA 20-09 (General Telemedicine Policy Update)
  • MSA 20-13 (Expansion of Telemedicine to Phone Only)
  • MSA 20-12 (Relaxing the Face-to-Face Requirement)

• Updates for Specific Provider Groups
  • Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC)
  • Community Mental Health Service Programs (CMHSP) and Prepaid Inpatient Health Plans (PIHP)
  • Maternal Infant Health Program (MIHP) Providers
  • Children’s Special Health Care Services (CSHCS) Providers
  • School-Based Providers

• Resources
High-Level Overview of the Department’s Response

• On March 10, 2020, Governor Gretchen Whitmer declared a state of emergency in response to the 2019 Novel Coronavirus Disease (COVID-19).

• Following this declaration, the Michigan Department of Health and Human Services (MDHHS) has been taking action to leverage available regulatory authorities to support Michigan’s healthcare infrastructure and maintain the commitment to high quality services and safety to Medicaid beneficiaries.

• Today’s presentation will focus on changes related to Medicaid policy and telehealth services. For more guidance and resources on other topics, please visit https://www.michigan.gov/coronavirus/ and click on “For Health Care Professionals.”
Michigan Medicaid Telemedicine: Overview
Michigan Medicaid Telemedicine: The Basics

• Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location.

• MDHHS requires a real time interactive system at both the originating (beneficiary location) and distant site (provider location), allowing instantaneous interaction between the patient and the health care professional via a telecommunication system.

• The technology must meet the needs of audio-visual compliance in accordance with current regulations and industry standards.

Important: originating and distant site provider must ensure the privacy of the beneficiary as well as the security of any information shared via telemedicine.
### Services allowed via Telemedicine (Telemedicine database)

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or other outpatient visits</td>
<td>Subsequent hospital care</td>
</tr>
<tr>
<td>Inpatient consultations</td>
<td>Behavioral Health &amp;/ or Substance</td>
</tr>
<tr>
<td>End Stage Renal Disease (ESRD) services</td>
<td>Psychiatric diagnostic procedures</td>
</tr>
<tr>
<td>Behavior change interventions</td>
<td>Nursing facility subsequent care</td>
</tr>
<tr>
<td>Diabetes Self-Management Training</td>
<td>Remote Retinal Imaging, Dx and management</td>
</tr>
<tr>
<td>Telehealth Site Facility Fee (only originating site allowed)</td>
<td></td>
</tr>
</tbody>
</table>

*Always consult the telemedicine database on the [MDHHS website](https://www.michigan.gov/health) for allowable codes*
Face to Face vs. Telemedicine

Certain services require a face to face component. For these services, a telehealth service cannot be used as a substitute but can be used in addition. These include:

- ESRD – requires at least one hands-on visit to view the vascular site.
- Nursing facility services require that the initial visit be face-to-face.
Billing for services performed via telemedicine must be reported utilizing BOTH:

- GT Modifier—Interactive communication
- POS 02—Telehealth
Authorized Originating Sites: Beneficiary Location

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center (FQHC)
- Hospital (inpatient, outpatient, or critical access hospital)
- Office of a Physician or other practitioner (including medical clinics)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Rural health clinic
- Skilled nursing facility
- Tribal Health Center
The distant site is the location of the physician or other practitioner providing the professional service.

These providers are subject to the same laws, rules & regulations that would apply to any face-to-face service. For example:

- HCPCS Code – The full requirements must be met in order to bill for any service. If the service requires an examination, then a facilitator can provide that hands on, but the distant site provider must apply their expertise in the exam in order to meet that requirement.
- Documentation – All required documentation rules should be followed.
Telehealth Site Facility Fee—Q3014

• Only allowed at the facility where the beneficiary is located during the allowable service.
• Must be an allowable originating site.
• Purpose: to cover the cost of hosting the beneficiary.
• Must ensure that the technology is functioning, the patient is comfortable, and that the information shared is secure.
• **Cannot** bill both the originating site fee and the code for the professional service for the same beneficiary at the same time.
Allowable Providers

MDHHS uses a reasonable approach to the use of telemedicine.

If all the answers to the questions below are “yes” then a physician or other qualified health professional (QHP) may provide the service using telemedicine.

• Is the physician or other QHP licensed under state law in Michigan?
• Is the physician or other QHP enrolled in CHAMPS?
• Is the physician or other QHP under contract with or authorized by an appropriate entity to provide the service?
• Is the service they are providing under their scope of practice?
• Is the physician or other QHP in the US or one of the recognized territories?
Overview of Recent Medicaid Policy Bulletins
Overview of New Medicaid Policy
Bulletins

• **MSA 20-09 (Issued March 12, 2020)**
  • Outlined the need for consent
    • Consistent with Section 16284 of the State of Michigan Public Act No. 359
  • Further defined Privacy and Security Requirements
  • Contingency plan is required including referral to acute care facility or Emergency Department as necessary
  • Expanded Originating Site Locations
    • Home—as defined as a location, other than a hospital or other facility, where the beneficiary receives care in a private resident
    • Local Health Departments
    • Any other established site considered appropriate by the provider, so long as all privacy and security requirements outlined in policy are established and maintained during the telemedicine service.
  • Relaxed Distant Site Provider requirements
  • Telehealth Facility Fee
    • Not allowed if originating site is home or another established site considered appropriate by the provider
    • Same provider cannot bill for both the telehealth facility fee and the code for the professional service at the same time.
    • Facility Rate—align with Medicare policy to only reimburse at the facility rate.
    • POS 02 and GT modifier
  • FQHC/RHC considerations
    • Allowed for FQHCs and RHCs to bill as the distant site provider and receive the Prospective Payment System (PPS)/All Inclusive Rate (AIR)
Overview of New Medicaid Policy Bulletins

MSA 20-13 (Issued March 20, 2020, Effective March 1, 2020)

• Issued in response to COVID-19

• Allowed for the services listed on the telemedicine database to be performed via telephone (audio only)

• Time-limited
COVID-19 Specific Database

MDHHS created a specific set of codes that are being covered for the pandemic.

Database is located on the website and is titled “COVID-19”

Codes cover a variety of providers—see notes

Includes first time ever telephone patient service codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99441</td>
<td>Physician telephone patient service, 5-10 minutes of medical discussion</td>
</tr>
<tr>
<td>99442</td>
<td>Physician telephone patient service, 11-20 minutes of medical discussion</td>
</tr>
<tr>
<td>99443</td>
<td>Physician telephone patient service, 21-30 minutes of medical discussion</td>
</tr>
</tbody>
</table>
Overview of New Medicaid Policy Bulletins

**MSA 20-12 (Relaxing the Face-to-Face Requirement) (Issued March 18, 2020)**

- This policy impacts: Home Help, MI Choice, PACE, Maternal Infant Health Program, MI Health Link, Medicaid Health Plans, CSHCS, Flint Waiver, PIHPs, and CMHSPs
- Allows flexibility related to in-person communication requirements to protect the health and welfare of beneficiaries and providers while maintaining access to vital services during the COVID-19 pandemic
- Providers may use telephonic, telemedicine and video technology commonly available on smart phones for program functions that require in-person communication. This includes initial assessments, re-assessments, LOCD assessments, PASARR assessments, care planning meetings, home visits, case management, and provider assessment and monitoring
- This does not include personal care services, home health, or other services designed to support Activities of Daily Living
Updates for Specific Provider Groups
Updates for Specific Provider Groups

• Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs)
  • Current Medicaid policy related to telemedicine applies to the FQHCs/RHCs
  • Originating Site – Home now allowable site
  • Clinics billing for telemedicine must use the institutional billing form
    • Include the appropriate telemedicine HCPCS/CPT
    • If the service constitutes a “Qualifying Visit”, must include Prospective Payment System (PPS) payment code (G-code/T-code)
    • Include corresponding modifier GT and Revenue Code
    • Q3014 does not qualify as face-to-face, therefore no PPS “Qualifying Visit”
    • If no provider-employee relationship, services not eligible to bill at FQHC/RHC PPS

• Provider Enrollment
  • Clinic contracted telemedicine providers must be associated with the FQHC/RHC billing National Provider Identifier (NPI) in CHAMPS to bill for telemedicine services
  • Provider-employee contracts must be maintained for audit purposes
  • Avoid duplicate billings
Updates for Specific Provider Groups

• Example #1 – FQHC/RHC is originating site and distant site
  • Originating Site – FQHC/RHC #1, Distant Site – FQHC/RHC #2
  • Billing Rules: FQHC/RHC #1 bills the telehealth facility fee (tracking purposes only), FQHC/RHC #2 bills the PPS for Qualifying Visit

• Example #2 – FQHC/RHC is originating site and distant site provider is employed by/contracted with originating site FQHC/RHC
  • Originating Site – FQHC/RHC, Distant Site – example, University of Michigan MD/DO
  • Billing Rules: Originating site FQHC/RHC bills for the distant site PPS Qualifying Visit

• Example #3 – FQHC/RHC is originating site and distant site provider is NOT employed by/contracted with FQHC/RHC
  • Originating Site – FQHC/RHC, Distant Site – example, non-contracted provider’s office
  • Billing Rules: Each provider bills for services provided at their site, no PPS

• Example #4 – Non-FQHC/RHC originating site, FQHC/RHC distant site
  • Originating Site – example, patients' home, Distant Site – FQHC/RHC
  • Billing Rules: Each provider bills for services provided at their site, FQHC/RHC PPS
Updates for Specific Provider Groups

CMHSPs and PIHPs

• The Behavioral Health and Developmental Disabilities Administration staff with clinical expertise in children’s mental health, substance use disorders, autism services, serious mental illness and services to individuals with intellectual and developmental disabilities compiled a code chart removing the face-to-face requirement for numerous services during the COVID-19 emergency.
• These services can now be provided via telemedicine including allowance for telephone only.

• A March 19th memo from Jeff Wieferich to PIHP and CMHSP CEOs provides the following guidance:
  • The allowance for the use of additional communication methods must not replace clinical need and clinical judgement when determining how to provide supports and services.
  • The provider qualifications for each service code have not changed and must continue to be followed.
  • It is the intent of BHDDA that services provided in these alternate manners be reimbursed as if they were face-to-face encounters.
Updates for Specific Provider Groups

CMHSPs and PIHPs cont.

- Some of the services that were opened:
  - Autism Assessments and other specific services
  - Health Services
  - Case Management
  - Crisis Interventions
  - Clubhouse Services
  - PMTO
  - Substance Use Disorder Services
  - Wraparound

- The code chart can be found on our website: [https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765-522278--,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_38765-522278--,00.html)

- Code Chart details:
  - The white rows are not available for any type of telehealth practices.
  - The green rows reflect currently allowable telehealth practices and can also now be provided through the means in the COVID-19 face-to-face guidance.
  - The yellow rows reflect currently unallowable telehealth practices that can now be provided through telehealth practices and through the means in COVID-19 face-to-face guidance.
  - The code chart is considered effective as of March 1, 2020.
  - The chart will be in effect for 30 days following the termination of the Governor’s Declaration of a State of Emergency Order (2020-04, COVID-19), or on the first of the following month, whichever is later.

- Questions: contact Kasi Hunziger at: HunzigerK@Michigan.gov
Updates for Specific Provider Groups

Maternal Infant Health Program (MIHP) Providers

• MIHP providers are temporarily allowed to provide telehealth visits (MSA 20-12)

• MIHP providers are crucial to providing community resource referrals, education, and continued prevention and support services to pregnant women and infants.

• Providers are following billing and reimbursement guidance from MSA 20-09.

• MSA Program Policy and the MIHP Operations team provided specific guidance to MIHP agencies including allowable codes and required program-level documentation requirements.
Updates for Specific Provider Groups

• **CSHCS Providers** - Social distancing for patients and medical teams

  • Children’s Multidisciplinary Specialty (CMDS) Clinics: procedure codes used by CMDS Clinics are covered for telehealth via MSA 20-12

    [https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html](https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42551-159815--,00.html)

  • CSHCS Medical Eligibility & Renewals: Accepting specialty telehealth visits in place of face-to-face visits during COVID-19 emergency (*follow-up after crisis*)

  • Local Health Department CSHCS staff: Using telehealth to support CSHCS families with case management and care coordination
Updates for Specific Provider Groups

School-Based Services Providers

• MSA 20-15 (Pending)
  • Establishes telepractice for behavioral health provided by the schools
  • Establishes permanent policy regarding telepractice for behavioral health
  • Includes a temporary provision for telephone-only behavioral health options
  • Temporarily allows parental/guardian consent to be collected via:
    • Electronic signature
    • Email
    • Witness telephone conversation

• Occupational and physical therapy telehealth options are also being considered
Final Thoughts

• Bulletins MSA 20-09, 20-12 and 20-13 are open for public comment

• MDHHS is considering other possible expansions to telemedicine policy especially with the COVID-19 pandemic

• Watch for new policies
Resources

• MSA 20-09
• MSA 20-13
• MSA 20-12
• Medicaid Provider Manual

• Telemedicine Fee Schedule
  www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information >> Physicians/Practitioners/Medical Clinics >> Telemedicine Services
Contact Information:
Laura Kilfoyle
KilfoyleL@michigan.gov
Questions and Answer Session

• To ask a question, select the Q&A icon on your screen and type your question.

• We will answer as many questions as time allows.

• In a few days, we will post a FAQ document to our website, including questions we don’t have time to answer.