Centers for Medicare & Medicaid Services
Special Open Door Forum: Telehealth
Moderator: Susie Butler
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(Robin): …about and have questions and answers. At that time you will need to press star followed by 1, mute your line, and record your name clearly as prompted. Today's conference is being recorded, and if you have any objections you may disconnect at this time. I'd now like to introduce Susie Butler. Ma'am, you may begin.

Susie Butler: (Robin) thank you so much. And I want to thank everybody for taking time today to join us, and thank you for the work you're doing and that your organizations are doing. It's so important, and I appreciate the fact that you're both staying safe and taking time out of your day to join us.

This special open-door forum is open to everyone. If you're a member of the Press you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you have Press questions or inquiries please contact the CMS at press@cms.hhs.gov.

So, I'm Susie Butler. I direct the Partner Relations Group in the Office of Communications here at CMS, and we want to bring this special open-door forum on telehealth to you today because we know there are a lot of questions on this topic. And so we thought we would have Emily Yoder from the Centers for Medicare Hospital and Ambulatory Policy Group, Division of Practitioner Services give a presentation just to give an overview, and then we'll go through a few questions before we open it up for general questions.

But before we do that, and have Emily speak, I'd like to turn the microphone over to Dr. Mary Greene. Mary is serving as a Senior Advisor in the Office of the Administrator, and she's going to just give us a broad overview of where we are right now and some of the policy pieces. Mary?

Mary Greene: Thanks Susie. I appreciate that. Good afternoon everyone, and thank you for joining the call. Susie asked me to talk particularly from the Patients over Paperwork perspective.

Before I start though, I also want to thank you for all that you're doing to take care of patients who have or might have COVID-19 while still attending to all of the patients who are still coming your way for other medical issues and other behavioral health issues. So thank you very much for everything that you're doing.

Patients over Paperwork is all about reducing administrative burdens so providers and clinicians can focus on patients, patient care. There is no more critical time to relax administrative requirements than right now during the - during the pandemic. CMS is relaxing requirements by issuing waivers, through rule-making, and by exercising new authorities like the authorities that we received through the recent CARES Act.

Our Patients over Paperwork team has been involved in the process of developing Medicare blanket waivers. We are capturing requests for waivers that come in to CMS, getting them adjudicated through our Medicare blanket waiver work group, then releasing those that are approved to the public. That work is just comprised of executive leadership across CMS, and policy subject matter experts across CMS, and we have that group together so we can get to decisions quickly.

CMS at this point has released over 66 blanket waivers so far, and we're still going. There are more blanket waivers to come. Just remember that these are blanket waivers that are valid through the - during the time of the pandemic.

If you want to learn more about the blanket waivers you can get the details from cms.gov current emergencies page. Actually, if you follow that page you'll get updates on the blanket waivers. You'll get updates on some of the rules that are out, and even some additional guidance.

Just to set a little bit more context for the conversation today, just a reminder that there are four main colors for CMS's strategy to issue these flexibilities. One is increasing hospital capacity. That we call CMS Hospitals Without Walls. CMS is allowing health systems and hospitals to provide services in locations beyond their walls, and that's to help address the urgent need to expand care capacity, and to develop sites dedicated to COVID-19 treatment. So that's the first one.

The second one is rapidly expanding the healthcare workforce. And CMS wants to add depth to the healthcare workforce since doctors, nurses, others on the front lines are being challenged like never before in terms of the volume of patients that they have to take care of, and also to avoid transmission among patients - virus transmission among patients.

So, for example, an example waiver is to allow hospitals to provide benefit and - benefits and support to their medical staff such as multiple daily meals, laundry services for personal clothing, or childcare services while the physicians and other staff are at the hospital providing care. We've also - have mechanisms to get through the paperwork part of and the process generally of - for providers and getting enrolled in Medicare.

The third one - the third prong is Patients over Paperwork which I already mentioned. We're relaxing some reporting requirements, delaying some timelines, decreasing some documentation requirements. An example is hospitals will not be required to have written policies on processes and visitation of patients who are in COVID-19 isolation. Or another example, hospitals will also have, excuse me, more time to provide patients a copy of their medical record.

So the fourth prong is further promoting telehealth and medicine. That's a topic for today. I want to thank you again for all that you're doing to take care of patients, and your families, and I hope very much yourselves as well, and I'll turn it over to Emily to talk about telehealth.

Emily Yoder: Thank you Dr. Greene. Hello everyone. I'm Emily Yoder. I'm an analyst in the Centers for Medicare and I work on Medicare telehealth. I am going to provide a summary of the changes to Medicare telehealth recently both through the waivers, and our recent interim final rule-making.

So as a refresher Medicare telehealth is - like under current law prior to the Public Health Emergency Declaration, telehealth was only allowed in - under Medicare in specific circumstances. So most significantly only beneficiaries in rural areas were eligible for telehealth services, and the beneficiaries needed to be in a medical facility, so not in their home.

That was, as I said, prior to the 1135 Waiver. Under waiver authority we were able to temporarily eliminate the requirement that originating site must be a healthcare facility, and allow Medicare to pay for telehealth services when beneficiaries are in their home.

We were also able to allow telehealth services to be furnished to beneficiaries in non-rural areas. I would note that we have additional waiver authority through the CARES Act, and we are still actually considering how best to deploy that additional authority.

So we also undertook interim final rule-making to as many of the remaining regulatory hurdles as possible. I'm going to go through the provisions of that rule now in a little bit more detail.

So, first of all we added a number of services to the Medicare telehealth list including initial inpatient and nursing facility visits, emergency department visits, initial and subsequent observation services, inpatient nursing facility and observation discharge day management, care planning for patients with cognitive impairment, home visits, and a number of physical therapy, occupational therapy, and speech language pathology services.

We also modified our requirements for billing for Medicare telehealth services. Rather than putting place of service "02" on the claim to identify the services as Medicare telehealth, we are instructing practitioners to put whatever place of service they would have used had the service occurred in-person, and append the 95 modifier to the claim to identify it as Medicare telehealth.

So, for example, if the physician furnishes a telehealth visit that's outside of the PHE would have occurred in an office, then she would put POS 11, and then the 95 modifier on the claim. We eliminated frequency limitations for subsequent inpatient and nursing facility visits and critical care consults.

Previously these services had frequency limitations for telehealth of once every three days, 30 days, and once a day respectively. We have elected to

exercise enforcement discretion regarding the statutory requirement that for ESRD services furnished via telehealth that there be a monthly hands-on evaluation of the vascular access sites for the first three months of home dialysis, and once every three months thereafter.

We amended our regulations text to clarify that the definition of interactive communications technology. We have heard from the community that because the reg tech referred to telephones as not being permissible technology for telehealth services that certain (MACs) were interpreting this as to exclude smartphones, which have the telecommunications technology that is real-time audio-video that is sufficient for Medicare telehealth.

For our communications technology-based services we removed the requirements that these be furnished to established patients, and expanded the practitioners eligible to bill for these services from practitioners who could independently bill for evaluation management visits to practitioners who cannot, so that, for example, licensed clinical social workers, clinical psychologists, or therapists could bill for these services when applicable.

There are also telephone evaluation management for assessment and management codes that we have long considered non-covered under this (inaudible) schedule, however for the purposes of the COVID-19 pandemic we changed these codes from non-covered to covered, and are now making separate payments.

We are also electing not to enforce the requirement in - that is in the code descriptor that these services be furnished only to established patients. We revised our definition of direct supervision to allow for the duration of the PHE that video technology - that direct supervision be provided using real-

time interactive audio-video technology, and this is based on the clinical judgement of the practitioner.

We also made sure that required visits and services in some other payment systems such as Home Health and Hospice, and the Hospice and the Opioid Treatment Program may be furnished via telehealth. For remote patient monitoring we removed the requirement that there be an established patient-practitioner relationship, we modified requirements that consent be obtained prior to furnishing the RPM service, and we clarified that RPM services can be furnished to patients with chronic and/or acute illnesses, and we confirmed that RPM treatment class management services can be furnished under general supervision.

To help teaching hospitals quickly expand their workforce medical residents will have more flexibility to provide services under the direction of the teaching physician. In addition to being able to directly supervise a resident with their physical presence during a - key portions of a procedure teaching physicians can now provide supervision virtually using audio-video communication technology.

And finally, for office outpatient evaluation management visits furnished via Medicare telehealth, we are adopting a framework that we had finalized previously for calendar year 2021 that medical decision-making or time we use for purposes of code selection, and that the history and exam be conducted as clinically necessary.

And I really want to highlight this change because in the context of the Medicare telehealth visit, this may be an important factor to practices moving more of their care to the virtual setting, especially if they are struggling with

how to perform and document the physical examination for purposes of billing the higher level office outpatient E&M visits.

And with that, I'm going to turn it back to Susie.

Susie Butler: Okay. Great. Thank you Emily. We're going to take a few questions in a moment, but we've had a few questions come in to the Partnership mailbox. So if it's okay we'll start with a couple there, and then we'll go as time allows to questions online.

So this first question that I have is a little bit about coding. Many physicians are asking about a telephone only without audio-visual capability for an E/M Level 2-3, code numbers 99212. 213, or NH 99308, 309 codes.

Due to their patient's age, limitation of having access to or being able to use audio-visual enabled technology patients do not have an iPhone which would have Facetime or they do not have a smartphone with audio-visual capabilities, and if they are in a facility without access, how can a provider service or care for them?

Can telephone only be used for visits when it is determined the patient does not have access or is incapable of using audio-visual technology? The same standard of care and level of documentation would be maintained.

Emily Yoder: Thanks. That is a question that we've actually gotten a lot recently.

So, currently Medicare telehealth rules state that the telecommunications technology must be real-time audio-video. So audio only telephones are not permissible at current for the purposes of Medicare telehealth, and that's

actually one of the reasons why we decided to make separate payment for those telephone assessment or evaluation codes.

However, what I will say is that the CARES Act has given us a significant authority to waive many or all of the statutory requirements associated with Medicare telehealth, and we are currently considering how to use that authority to address some of these issues with beneficiaries not having access to or not knowing how to use the two-way audio-video telecommunications technology.

Susie Butler: Great. Thank you. The next question from (Rick), he wants to know, "Any update or progress in adding physical therapists, occupational therapists, and speech language pathologist as providers of telehealth services during the Public Health Emergency due to the COVID-19 pandemic? If yes, would this include PTs, OTs, and SLPs who practice in institutional settings and submit claims on a UB-04 claim form in addition to PTs, OTs, and SLPs who practice in a private practice setting and submit claims on a 1500 claim form?"

Emily Yoder: So, similarly to the prior question about audio only the statute does provide a specific list of practitioners who may furnish Medicare telehealth services, and therapists - the physical therapist, occupational therapists, and speech language pathologists are currently not on that list of eligible practitioners.

So, similarly again to the audio only issue we are considering how to best use the waiver authority associated with the CARES Act to address what we've heard from many therapists, that they can, you know, furnish their services or some or some of their services via Medicare telehealth.

In terms of what you would put on the claim we would, if we were to sort of move forward with expanding the list of practitioners who can furnish Medicare telehealth, provide more detailed billing guidance at that time.

Susie Butler: Great. Thank you. And then the final one I have from the mailbox is from (Laurie), and she's asking, "In the event we are not able to provide an in-person visit at the request of the beneficiary or facility administration where the beneficiary resides, and the offer of a two-way audio-visual telehealth visit is declined as the beneficiary or facility being unable to support, may we proceed with a two-way audio telephone visit including assessments? The current clarification regarding 410.78 A3 does not indicate we would be permitted to conduct these Hospice visits and/or assessments by telephone. The guidance I have reviewed is below," and she includes all of that guidance.

Emily Yoder: Yes. So right now the visits for purposes of Hospice or the other payment systems, those do - are subject to the Medicare telehealth rules, and so would require the two-way audio-video telecommunications technology for what the - what is supposed to be the - sort of the face-to-face in-person portion of those visits. So yes, they would need two-way audio-video.

Susie Butler: Okay. Thank you Emily. (Robin) let's open it up. We'll try to take a few questions live. (Robin)?

(Robin): At this time I have (Lindsey Long). Your line's open.

(Lindsey Long): Hi. We do a provider-based billing with our organization, and it suggested that we continue to bill our services as we normally have as if the patient were standing in the office with the addition of the modifier. Does this mean that we should also continue to bill our facility fee?

Emily Yoder: So, just so I'm understanding. So is the patient in the - so is the - is the distance site practitioner the person who is furnishing the Medicare telehealth service, are they part of the provider-based department or is that just the location of the patient?

(Lindsey Long): I'm sorry. Can you repeat your question?

Emily Yoder: So, as you - I'm sure you know there's sort of queue portions to the Medicare telehealth services. The originating site which bills the originating site facility fee, and then there is the distance site that's - that isn't that practitioner bills the CPT code.

So, in your case is the distance site practitioner in the provider-based department or is that the location of the beneficiary?

(Lindsey Long): It's the provider.

Emily Yoder: It's…

(Lindsey Long): Not the - not the patient.

Emily Yoder: So that they would - got you. Okay, yes. So they would bill as though the visit occurred in the provider-based department, and they would use the place of service code associated with that - with that place.

(Female): Okay.

((Crosstalk))

(Robin): And (Lindsey), does that finish the question?

(Lindsey Long): So that's how we would apply it to the facility fee portions, correct?

Emily Yoder: Yes, you would be receiving the facility payment. Right, that is correct.

(Lindsey Long): Okay. Thank you.

(Robin): Our next question is from (Tom Norton). Your line's open.

(Tom Norton): Hi. I did have my question, but I think there was a misunderstanding on the previous question. I think she was asking if the hospital gets to bill the facility portion of their fee, and the physician bills their fee. I think that's what she was asking, and I don't think that was answered.

But in any case, my question is yesterday on a call I heard that if the provider and the patient are on the same campus, but not in the same room or on the same floor, or even in the same building that we don't treat that - and they do a telehealth visit we don't treat it as a telehealth visit. We treat it as if it were just done in-person.

So I wanted to ask what if we have an inpatient with a nurse in the room who uploads a photograph, but then it's only provider on the telephone with the nurse and the patient? So the provider's on campus, but not in the room, nurse is in the room with the patient, and now the provider is speaking by telephone to the nurse and the patient and reviewing a photograph of the affected area that's being treated.

Can that be treated as a regular hospital care visit or does it have to be video and audio in order to treat it as that?

Emily Yoder: So, with reference to the previous caller, I appreciate what you're saying, and if she wants to reach out to us with an email we could get some more clarity on - on - on her question because I want to make sure we're answering these thoroughly and accurately.

As for your question I think what we would say is that they should report the services they are furnishing, and this was the response basically that was given on the call yesterday. And so if they're meeting the requirements for a hospital visit, for example, the sort of telephone and evaluation of the image or, you know, whatever, then they would bill.

As long as they're meeting all the scope of service requirements, then they would just bill for the hospital visit, and they wouldn't need to put the telehealth modifier on the claim or anything like that.

(Tom Norton): Okay. Thank you.

(Robin): Thank you. Our next question will come from (Sheila Clark). Your line's open. (Sheila Clark) your line's open. I'll move to the next question. (Jill Young) your line's open.

(Jill Young): Goodness you caught me. Excuse me. First of all I'd like to thank you for telling us that you are giving consideration under your waiver authority to allow for certain things to happen because our physicians are taking a tremendous hit for patients that do not have that visual capability in order to bill a telehealth code.

I'm sure, as you know, the reimbursements for the telephone codes versus the reimbursement for a telehealth is double, and when patients do not have that capability at all it certainly seems unfair. You know, in certain populations,

certain types of specialists and their populations are 50, 75 percent Medicare, so they're taking a significant financial hit in trying to keep their doors open.

My question is should doctors be holding claims that they are providing the telephone only service, and if they've already filed claims inappropriately as we realize we shouldn't have been filing with place of service 02, will they be able to appeal those that were paid with the facility discounting - will they be able to appeal those to gain the extra seven - .7 RVUs that they missed out on for payment in the future?

Emily Yoder: Yes. So, for purposes of whether or not sort of audio only will be allowable for telehealth in the future I sort of can't speak to how, you know, you should view the claims that could or could not be submitted in light of that change. What I - we can't speak to that right now. But we're also - any sort of - there's no editing or anything associated with place of service 2, so you can still continue to use place of service 2.

When it comes to claims that were submitted perhaps prior to the interim final rule that perhaps would be the different place of service than place of service 02, if you could follow-up with us in writing about that I can hopefully provide - get the answer to that question for you.

Thank you.

(Jill Young): Okay. Thank you.

(Robin): Thank you. Our next question is from (Kaitlyn O'Connor). Your line's open.

(Kaitlyn O'Connor): Hi. Thank you. So my question is related to e-Visits and some clarity around the e-Visit codes that we have currently in place. For the HCPCS

codes that are specifically for non-physician practitioners, and actually for the physician codes as well, the CPT manual I believe says that these codes require a patient portal to be used, but for the non-physician codes it also contemplates just digital assessments.

And so my question, one, is what exactly is meant by a patient portal? And second, does that contemplate the use of automated digital assessments that are sent to a patient, filled out, and then sent back to the practitioner to be reviewed and to follow-up as necessary?

Emily Yoder: So, I am going to ask you to send that question to us in writing so that we can get an answer for you because I can't speak to it right now.

Thank you.

(Kaitlyn O'Connor): Okay. So Emily, should I just send that to you directly?

Emily Yoder: Yes, please. Thank you.

(Kaitlyn O'Connor): Okay. Thank you.

(Robin): Thank you. Our next question is (Ruth Clark). Your line's open.

(Ruth Clark): Hi. Thank you for taking my call. Appreciate this platform and the opportunity to get some answers and ask questions.

I'm with the Kansas Medical Society representing about 3,000 actively practicing physicians, many of whom are in rural parts of the state. As you're aware early on there was an issue with RHCs performing as the distance site. I believe that's been addressed, but what hasn't been addressed is the guidance

on how or how much rural health clinics and FQHCs will be paid by Medicare for telehealth visits.

Has there been any movement on that? Can - do we think rural health is going to be able to expect their normal fee on these services?

Emily Yoder: Yes. So I can speak a little bit to that, although I'm not actually the RHC FQHC expert. But I believe that we're still working on like how those services would be reimbursed and sort of what the payment rate would be.

So stay tuned for more information hopefully forthcoming on that question.

(Ruth Clark): Is there - is there somebody at CMS - you said you weren't the RHC person. Is there somebody that we could reach out to that we could communicate with?

Emily Yoder: I think what we'd have you do is send your inquiry to the COVID inquiry box, and I think that Susie can provide you with that information, and then they'll make sure that it gets routed to the right person here at the agency.

(Ruth Clark): Great. Thank you.

Susie Butler: And actually I'm going to have you send it to the Partnership box, which is partnership@cms.hhs.gov. That way we don't have to find it in the COVID box, and we can get it routed immediately.

(Ruth Clark): And, I'm sorry, that was partnership…

Susie Butler: At cms dot hhs dot gov.

(Ruth Clark): Thank you.

Emily Yoder: Thank you Susie.

Susie Butler: Sure. Sure.

(Robin): Thank you. Our next question is (Stephanie Baxter). Your line's open.

(Stephanie Baxter): Hi. Good afternoon. My question is about how should hospitals bill when they are performing daily subsequent visits by audio only? We read the guidelines and it looks like CMS info instructs hospitals to use the telephone E&M codes, the 99441 through 443 when performing the telephone audio only services in the inpatient setting, but these codes are limited to services where the provided - there's no prior E&M has occurred. So we're just trying to get some clarification on the subsequent hospital visits by audio only.

Emily Yoder: Yes. So, is this a situation where the practitioner who's furnishing the visit is not physically at the hospital? They're someplace else like in their homes?

(Stephanie Baxter): I'm sorry, I don't have that piece.

Emily Yoder: Because we sort of have - kind of it's - there's different guidance depending on where the distance site practitioner is located.

So what we've said is that when there's - there's - we've received the question a lot, and I think I took it on this call. There's instances where the patient and the practitioner are both in the same setting, but because of sort of concerns about quarantine that the practitioner is not physically in the room with the patient, and they are sort of communicating via some sort of telecommunications…

(Stephanie Baxter): Yes.

Emily Yoder: …technology, and they're sort of furnishing a visit that way. Is that what's happening to here or is this…

(Stephanie Baxter): Yes.

Emily Yoder: …(inaudible) where…

(Stephanie Baxter): Yes. Yes, we're looking for - in the separate setting. The provider and the patient are in different locations.

Emily Yoder: Okay, great. So, in that instance we would say to bill the - those phone visits, but we don't - we're - right now we're not sort of enforcing that they have to be sort of - it can be either a new or an established patient receiving those - receiving those…

(Stephanie Baxter): Okay.

Emily Yoder: …services. Does that answer your question?

(Stephanie Baxter): Yes. So on that subsequent day we could still use the 99441 codes?

Emily Yoder: Yes. Absolutely.

(Stephanie Baxter): Okay. Thank you very much.

(Robin): Thank you. Our next question is (Elaine Blank). Your line's open.

(Eileen Blank): Hi, this is (Eileen). We're an FQHC, and our question is we were trying to determine what codes, what place of service, and what modifiers we need to get, and what G or T codes we need to get so that we would be enabled to get our full rate rather than a reduced rate for the telehealth only.

Emily Yoder: So, I am going to direct you to email the Partnership refers box, and that question can then be routed to the appropriate subject matter experts for RSCs and HTSCs.

(Eileen Blank): Okay. I will…

Susie Butler: And I'll give you that box again. It's partnership@cms.hhs.gov.

(Eileen Blank): Okay. I just was double-checking. I appreciate everything you're trying to do for us. That's it.

(Robin): Thank you. Our next question is (Cynthia Young). Your line's open.

(Cynthia Young): Yes. I have a question regarding the onset when all this started and the patient had to initiate the telemedicine call, but now can the doctor just call the patient or does the patient have to request the call?

Emily Yoder: So, I think what we're - what we're saying here is that the patient can definitely sort of consent to receiving a more proactive sort of phone interaction with their practitioner.

So they could say, you know, "For the purposes of the pandemic, you know, if you need - if you need to call me…" - like they can sort of - they can consider it patient-initiated even if it isn't initiated - even if the individual interaction isn't initiated by the patient at that time if the patient says, "Okay, like it's fine

if - for the purposes of communicating with me about COVID-19 that it's - you can, you know, you can call me to check in," or whatever.

What we don't want to have happen is a situation where there's some sort of like where doctors are just cold-calling patients, and then sort of billing for the virtual check-in, which we really don't think is a possibility, but we do want to have a little - a few guardrails around the chance that that would happen.

So does that answer your question?

(Cynthia Young): Yes, but like we were told we could do annual exams through telemedicine, and bill for the annual exams because the doctor would see them and talk to them and everything. So…

Emily Yoder: Yes. So (inaudible).

(Cynthia Young): …can we just use them off our appointment schedule and call them, or do we have to…

((Crosstalk))

(Cynthia Young): …ask them do they want to reschedule, or can we just call them because they're on our schedule for that day for an annual, or how does that work?

Emily Yoder: Right. So, I'm sorry. For Medicare telehealth there are no restrictions on who has to initiate the service.

These are just - I was just speaking strictly to the - like the virtual check-in for the remote I think point of service where we have specified that those need to be patient-initiated in some way. But for something like the annual wellness

visit when conducted via Medicare telehealth that's - there's no - there's no rules around that.

(Cynthia Yoder): Okay. And those can be or can't be audio only?

Emily Yoder: So right now something like the annual wellness visit when furnished via Medicare telehealth would need to be audio-video.

(Cynthia Yoder): Okay. All right. That's my question. Thank you very much.

Emily Yoder: You're welcome.

(Robin): Thank you. Next question is (MaryAnn). Your line's open.

(MaryAnn): Hi. I'm representing - can you hear me?

Emily Yoder: Yes. Thank you.

(MaryAnn): Okay. I'm representing mental health, and everything that we're seeing and reading we're not seeing anything pertaining to actual psychotherapy.

We saw the guidance for E&M for telephone only, but, again, it was stated earlier this population is the protected population and should not be out and about, and then they have the challenges of their ability to use the televisual equipment if indeed they own televisual equipment. And we don't want to, you know, we want - we want to provide, we are providing services to continue care and assess additional anxiety due to the pandemic, but these clients only have telephone.

So, I don't think it's in - been addressed particularly toward the mental health population. And I know that colleagues of ours are faced with the same question and concern about how do we get paid for these continued services and/or additional services mainly due to their anxiety and stress level and phobias?

Emily Yoder: Yes, absolutely, and we've heard this issue sort of - we've heard loud and clear that this is a real serious issue, particularly when it pertains to behavioral healthcare services.

Especially as you rightly point out that at a time like this with the - with the pandemic and the social distancing that many people are experiencing heightened anxiety right now, and actually have a greater need for behavioral healthcare services than ever before, and that's why we're really looking at the additional waiver authority associated with the CARES Act to see if we can do anything about the restrictions for Medicare telehealth on the two-way audio-video, and see if there's something that we can do to make audio only accessible for beneficiaries during that time.

So we're definitely taking this very seriously and looking into how we can best address it.

(MaryAnn): So every provider right now we're holding that billing, but we're continuing to provide the service because there's a client need, and we would feel it would be unethical just because we can't bill for it. But it is hurting the practice because we, as most mental health agencies, are non-profit, and, you know, so that is - a lot of our population is Medicare.

And so we'll anxiously await and hope that there will be a quick decision on this. And if there is what I assume that we would bill the new codes with the

place of service 11, and 95 if indeed the therapy codes were approved to be telephone only.

Emily Yoder: Yes. So, in - is - if that comes to pass, then what you described as how you would bill for it is correct. And we definitely appreciate you continuing to bring this to our attention because we believe it's very important.

(MaryAnn): Do I need to submit this in writing also to the Partnership email address that was shared?

Emily Yoder: Sure.

(MaryAnn): Okay. Thank you.

(Robin): Thank you. Our next question is (Britt McDavid). Your line's open.

(Mark McDavid): Yes, this is (Mark McDavid). I was calling, we work in the skilled nursing space, and as many of us are trying to limit exposure from patients and staff members, and so we're kind of segregating our teams if we have a large enough team and a large enough skilled nursing facility so that we can put a PT, OT, and Speech team on one wing, and one on another.

My question is related to supervisory visits, as well as being able to do evaluations. If we have a PT, if we've got a team that's big enough to split, but we don't have a PT, we only have one, and we have several PTAs, so we put PTAs on say our COVID wing, and the PT and a couple of PTAs are on the non-COVID wing, we don't want that PT going back and forth.

Since they're on-site would it be possible for the PT via some mechanism of telehealth, iPads or whatnot, to have the PT go sit with the patient and be able

to do that supervisory visit, one, and an evaluation with the PT via telehealth while they're in the same building, just not in the same room?

Emily Yoder: So, I think this is very similar to the instance where you sort of - you have a practitioner and you have a patient, and they're in the same location, and they can communicate, but they're physically sort of separated.

In…

(Mark McDavid): Correct.

Emily Yoder: …that instance what we're saying is that you can sort of consider the iPad or the audio-video or the audio - or, you know, whatever combination is working for you as being a face-to-face, as sort of standing in…

(Mark McDavid): Okay.

Emily Yoder: …for a face-to-face for whatever the face-to-face portion of the service is. And so you wouldn't actually need to bill anything as telehealth. You would just bill the service…

(Mark McDavid): Sure.

Emily Yoder: …that you would have furnished normally.

(Mark McDavid): As though it were a face-to-face.

((Crosstalk))

(Mark McDavid): Got it.

Emily Yoder: (Inaudible).

(Mark McDavid): Okay. Thank you so much.

Emily Yoder: Okay. Yes. You're welcome.

(Robin): Thank you. Next question is (Susan Pelch). Your line's open.

(Susan Pelch): Hi. Thank you. I'm with the American Academy of Audiology. I know the agency has expanded access to PT, OT, and SLP services, and you mentioned earlier on an earlier caller that you are looking at the waiver authority to allow, you know, other providers to provide the telehealth services.

Audiology is an area that has not been addressed in any of the legislation or waivers. Untreated hearing loss is an isolating factor is in - in and of itself, which is now being compounded by the lockdowns in many senior facilities.

Will the agency consider taking action to allow audiology services to be provided via telehealth, and for audiologists be able - to be able to provide those?

Emily Yoder: Yes. So we're currently thinking broadly and expansively about telehealth. And so if you wanted to send us information on sort of which services do you think could be furnished via telehealth, and sort of how one would furnish an audiology service via telehealth that would be really, really helpful for us as we sort of consider what further services we could add to the Medicare telehealth list.

(Susan Pelch): That would be great. And should I send it to the Partnership mailbox?

Emily Yoder: Yes.

(Susan Pelch): Okay. That'd be great. And I just will - I'll put that in my email as well, but the VA has a very expansive tele-audiology program and has for many years. So, I will be certain to provide that information. Thank you.

Emily Yoder: Great. No, thank you so much.

(Robin): (Russell) your line's open.

(Female): Hello? Is that me? I can't hear you. Hello?

(Robin): (Jean Russell) your line's open.

(Jean Russell): Oh, thank you. Okay. So I am going to clarify because I have the same question that somebody asked earlier, but I don't believe it was answered.

If we provide telehealth care in a hospital-based setting, outpatient setting, so we have hospital-based clinics that typically would be split-billing to Medicare for a face-to-face visit with a code like G0463, a medical visit on a technical claim, and then an E&M visit on a professional claim.

If we do this as telehealth, so how do we bill that? What place of service do we bill, and can we get the G0463 technical claim?

Emily Yoder: Can you please send that question to the Partnership mailbox?

(Jean Russell): I did.

Emily Yoder: I would need to look at - sorry. Okay?

(Jean Russell): Okay. All right. Thank you. Because that is - it's - all of our hospital clients are asking that question, and I don't believe that that's - we've got that answer to that question yet.

Emily Yoder: Okay. Great. Thank you.

Susie Butler: Okay. Thanks.

Female: Next question.

Susie Butler: We have time for one more question (Robin).

(Robin): All right. And our last question is from (Patrick Miller). Your line's open.

(Patrick Miller): Yes. Hi. I'm a clinical manager at a Medicare certified Home Healthcare agency, and I heard - did hear the question earlier from the gentleman asking about therapy visits, and it seemed like that was more about telehealth for clinicians in outpatient or inpatient settings.

And I - I - I'm just - was wondering can therapists, PTs, OTs, and SLPs can we bill for - under Medicare Part A for telehealth visits at this time?

Emily Yoder: So I believe we're actually still working on how to address that question. So hopefully they'll be some additional guidance forthcoming on that because we have been getting that question as well frequently.

(Patrick Miller): Oh okay. Fantastic. Thank you.

Emily Yoder: And thank you.

Susie Butler: Folks, I want to thank you all. This is Susie again. I want to thank you all for joining us today. The Partnership Resource box which I have referenced a couple of times, partnership@cms.hhs.gov is there for you to send your questions to.

We won't answer them. We will try to find the right answers, and either get back to you or see that those answers influence how we're looking at things, as well as future frequently asked questions, but we'll try to get the questions that were specifically asked today to Emily so that she can funnel those to the appropriate people or answer them herself.

I will also say we had a bit of an influx of questions to the Press box because we had a disclaimer on the invite saying, "If you have a Press question call the Press Office," and I think people were so anxious to get information that people were just asking the Press Office questions anyway. So, we'll try to reword that for the future.

The other question for you - or the other statement for you is we will post this call as soon as we get the recording, and post the transcript within 48-hours after we get the recording. We post those on our podcast page, but rather than give you a long email address you go to cms.gov and on the front page there you will see a big picture of the graphic from CDC, the Coronavirus, and you click on that. That's our emergency page. If you scroll all the way to the bottom and you'll see Partner Tools, and there's a toolkit, and our podcast link.

So you'll be able to listen to the beginning if you weren't able to get on at the beginning, as well as reference other recordings that have occurred in the last several weeks.

So, again, thank you for your time today. Thank you for tuning in. Apologies if you had difficulties getting in. We had over 4,000 people I believe on the line today, so it was a little bit of a challenge getting everybody in the door.

Thanks to Emily, thanks to Mary, and thanks to all of you. Please be safe, stay in touch, and we'll be back with more information soon.

(Robin): And thank you. This does conclude today's conference call. You may disconnect your lines, and thank you for your participation.

End