Telehealth, Now and after PHE
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As we are now well into 2021, and over 12-months from the beginning of the first announced PHE (public health emergency), the past year has been a whirlwind of medical practices having to pivot to a new delivery of care, Telemedicine. This platform, also referred to as Telehealth, has seen an uptick of visits in the 80-90% range of overall patient outpatient encounters according to MGMA.

CMS and other Commercial payers adjusted their coverage policies to allow for these types of visits, virtual and remote care, when the patient is in their home, and their care is delivered by an audio and video platform, or through a telephone call. The reason that the insurance payers have allowed Telehealth during the PHE, is to limit the spread of COVID-19 and to protect the most vulnerable to the virus, but still allowing for needed care.

Many pro-Telehealth entities and providers are advocating to continue with the current, PHE rules of Telemedicine delivery once the PHE end, but as the OIG stated in their 2021 Work Plan, assess the overall effectiveness of Telehealth and to ensure it is not just a convenience over a medically necessary delivery of medicine.

With the 2021 Medicare PFS (Physician Fee Schedule) changes and the CMS C.A.R.E.S act Flexibilty's set to roll back once the PHE ends, what can you do now in your practice to prepare for potential changes in reimbursement and coverage?

The first thing to realize is, that the PHE is temporary. Yes, the COVID-19 virus challenges may take us through the end of 2021 to slow, and as vaccines increase, there is a light at the end of the tunnel, but the PHE, in the truest of definitions, will end at some point. That will mean regulations will be rolled back; to what

extent we are not completely sure, but we have the Social Security Act and CMS rules to follow and that cannot be changed unless an act of Congress does so and that takes months, even years to make happen.

In the NSCHBC Edge Podcast February 9th, we discussed this very question and how practices should handle the potential transition, once the PHE ends. But the question, "Are you all-in on Telehealth or is this a stopgap during PHE?" has to be answered first. How much is your practice willing to spend to make sure that your patients have equal access to an audio and video platform? Many patients still do not have the highspeed internet needed to engage in Telehealth services, and when the PHE ends, non-HIPAA protected platforms such as FaceTime and Skype will no longer be an option.

Also, one of the flexibility rules that will be rolled back to the original Telehealth regulation, will be the "individual receiving the service must be located in a telehealth originating site". This means, the patient's home will not be an option, once the PHE ends, unless the patient qualifies in a HPSA (Health Professional Shortage Area) area or is a mental health patient.

Under the CARES Act, Congress gave CMS the ability to waive the geographic location requirement during the COVID-19 PHE.
The current Public Health Emergency (PHE) is in effect through April 22, 2021, per www.phe.gov for certain RPM services through December 31, 2021 (the year in which the PHE ends).

My first introduction to the actual use of Telehealth was when I appeared in a webinar sponsored by the Cincinnati Academy of Medicine. Our topic was how to conduct a Telehealth visit. The training session was a thoracic surgeon and myself doing a "mock Telehealth visit". He emphasized being professional in his appearance, and said "wear your white coat, stethoscope around your neck and make sure the dog doesn't bark while you are Face-Timing with your patients". We also discussed making sure the ancillary staff gives patients rules for their Telehealth visit, as in appropriate attire, sitting in a chair and no laying down in their beds while on a call, unless they are disabled, along with making sure they have as much privacy on the call as possible. With, Medicare currently paying for office visits at the same rate as if the patient was in-person, and with the same POS, during the PHE, the encounter should be as similar as an in-person visit.

CMS, in the 2021 Final Rule, grouped the Telehealth services into three categories as we navigate this next year during the PHE:

- Category 1: services/CPT/HCPCS codes that will become permanent after the PHE is over;
- Category 2: services/CPT/HCPCS codes that will be removed when the PHE expires; and
- Category 3: services/CPT/HCPCS codes added to the list, but only on a temporary basis.

Category 3 codes, such as physical and occupational therapy, initial hospital care discharge day management, inpatient neonatal and Pediatric critical care, initial and subsequent may not remain after the PHE expires. CMS has also been clear that audio only phone call codes, 99441-99442, will not be covered under the Telehealth provision, once the PHE ends, and created a new G-code G2252 as a 11-20-minute audio-only code cross-walked to code 99442 to allow for an encounter when the physician may not be able to have an encounter to visualize the patient.

We cannot foresee into the future on where Telehealth is going, but as one recent CMS "Office Hours Calls" pointed out when asked about the patient's' home as a valid place of service (POS) continuing after the PHE ends, they stated "No". Again, only for HRSA (rural Health Professional Shortage Area) or MSA (Metropolitan Statistical Area) patients, or for patients suffering from mental illness was that a possibility. That is a huge determining factor when a patient chooses to use Telehealth or not. If they have to leave their house anyway to transport to an "approved" originating site, such as a hospital, physician's office or other medical facility, they might as well keep driving to their physician's office if that is the only option.

Commercial plans may allow more flexibility on this delivery of medicine since they are contract providers and can basically call their own shots when it comes to coverage.

The healthcare consultants at NSCHBC want to advise our clients, and potential clients to do their due diligence, and determine if you will continue with offering Telehealth in the future in your practice, and what will be your business model for that offering? Most practices have said they will offer it, but it would be a good idea

to survey your patients to find out what they would do if suddenly their home was not an approved site to receive Telehealth benefits. Would they pay cash? Would they still engage? Or would they go back to the in-person care? A question for providers that have been using the PHE allowed smart phone device platforms such as FaceTime and Skype, **“**Will you invest in additional software to be HIPAA compliant?” These are questions to ask, as you prepare for another pivot in your delivery of medicine once the PHE ends.

Stay tuned to this ever-changing virtual delivery of medicine and how, after PHE, the reimbursement process will be handled and how it will affect continued payer coverage in medical practices.

You can listen to our NSCHBC Edge Podcast the second Tuesday of every month, on all podcast platforms.

References and Resources:

https://oig.hhs.gov/coronavirus/letter-grimm-02262021.asp?utm_source=oig-web&utm_medium=oig-covid-policies&utm_campaign=oig-grimm-letter-02262021

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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