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ARIA JAVIDAN:
Hello, everyone. The webinar will begin momentarily.

SPEAKER:
Recording in progress.

ARIA JAVIDAN:
Hello, I am the project manager for the national consortium of telehealth resource centers. Welcome to today's special webinar. Federal telehealth policy in 2025. Cohosted with the Stanford connected health policy and this session will be the recent actions Congress has or has not taken in regards to the federal waivers on middle care held a let telehealth policies. It is change and what is continuing.

A little bit of background on the consortium located throughout the country. There are 12 regional telehealth resource centers and to national. One focused on telehealth policy, and the other on telehealth psychology assessment. Each service focal points for the effective use of telehealth and supporting access to telehealth services in rural and underserved communities.

A few tips before we get started today. Audio has been muted. Please use a Q&A function of the zoom platform to ask questions. Questions will be answered at the end of the presentation. These only use chat for communicating issues with technology orc munication access issues. Refrain using chat to ask questions or make comments.

Also note that closed captioning is available and it is located at the bottom of your screen. Today's webinar is also being recorded and you will be able to access today's and past webinars on the YouTube channel and the website telehealth resource Center.org.

I will pass it over to today's speaker, Mei Kwong.

MEI KWONG:
Thank you, Ari and thank you everyone. Before we get started I want to say I hope everyone is staying safe, healthy and happy. There's a lot going on in the world today so I wish everybody is staying safe now.

My name is Mei Kwong. Executive Director the Center for Connected Health Policy. Today we will be talking about what's going on on the federal level in regard to telehealth policy. I touch a little bit on what's going on in the states as well.

A few disclaimers before we get started today. Please note that any information provided in today's talk should not be considered legal advice. It is strict for informational and educational purposes. If you do want formal legal opinion we recommend you consult with legal counsel, and also know if I happen to mention a company or picture of a product know that neither I nor CCHP has any type of financial relationship or affiliation with such a company.

A bit of background about CCHP. We started as a California telehealth policy organization is a program underneath the public health Institute. Founded in 2009. An opportunity to become the federally designated national telehealth policy resource Center became available in 2012 through funding from HRSA.

We applied and got that funding and have been serving that capacity ever since. There are actually 13 other telehealth resource centers and he went over that with you so I will not repeat that, but no we all work collaboratively together. While we highly recommend that you reach out to your regional telehealth resource Center that covers the specific state you're interested in if you happen to reach out to any of us we will make sure you get to the right person if that particular person is not the right want to contact with your question.

CCHP axes administrator for national Consortium telehealth resource Center and that means we provide a focal point for munication for folks. Not trying to figure out which ones to reach if they don't know exactly or if they are not trying to reach out to all 14 of us if they want to talk to all the organizations.

CCHP also runs a group in California called California telehealth policy coalition. That is devoted to California State telehealth policy. If you are interested in that please reach out to CCHP and I can provide you with more information about that.

Ari has already gone over this. I really want to encourage everyone. If you have not please reach out to the telehealth resource Center. I always say they are the most knowledgeable folks in the country around telehealth. Combined we have hundreds of years of experience with telehealth policy, telehealth operations, just basically everything related to telehealth. I highly encourage you to reach out to your telehealth resource Center.

For today we are going to go over a couple of things. Ari mentioned this would be a federal policy and recent action by Congress, and that's definitely part of the presentation, but I wanted to go over a couple of things as well.

Just because given the questions that have come in recently to CCHP there still seems to be confusion

out there on what policies are in place and certain actions that have happened that have caused confusion because maybe certain policies are in conflict or seem to contradict each other. I want to clear up some of those frequent asked questions that we have been receiving at CCHP. And then talk a little bit more about other federally related telehealth policies, and as well as a little bit of what's going on in the states.

First, for those who may not be as familiar with it these are sort of your main sources of how telehealth policies is developed. It's really for any policy no matter what you're talking about. Most people are familiar with the first two legislation and regulations. A governing body such as Congress or your state legislature passes a law. It is put into place and there's usually an agency that oversees the implementation of that law. Some sort of regulatory agency or ministry agency. Then they promulgate regulations on how that law would be carried out, how would be enforced. And then they also may issue agency guidelines or letters.

For those who might be familiar with Medicaid programs sometimes you might get a provider letter that is sent out by the Medicaid agency. It's not regulations or laws but sort of a further clarification of their policy.

The fourth one, court cases, people may not be as familiar with it but over the last couple of years it's gained a lot more relevancy and developmental of policy particularly in telehealth. Those are important to keep an eye on. I wanted to start off by talking about these because this is kind of where we get into some of the confusion because there may be like a law in place, but then you will see something that was done on the regulatory side of things and you're like, seems I get kind of commuting or in conflict with each other. I wanted to be sure everyone understood these are all elements that go into developing telehealth policy, and usually it works in a linear fashion in that it goes laws, regulations, guidelines if there needs to be further clarifications, but sometimes things get a little offkilter due to various factors as well. We will talk more about how that may happen with some of the telehealth policy elements currently going on right now.

First, federal CMS and Medicare reimbursement and coverage. Most of you are probably aware of this that Medicare telehealth policy abolition this is a really high level overview of that. Before COVID-19 for telehealth Medicare policy was concerned it was very restricted telehealth policy in the nation. A lot had really advanced or ahead of what Medicare was doing.

These policies, the pre-COVID ones, the permanent, from now on I'll refer to them as permanent Medicare telehealth policy, were really restrictive. There were requirements and limitations on where the patient had to be located in order for that telehealth visit to qualify perfume burst went. That was limited by both geography and also by sight. For those who may not be familiar the geographic limitation was

that it had to be in a rural health professional shortage area or non-metropolitan statistical area so is very limiting in those eligible locations could be.

To top it off you also had to meet like a site requirement and the patient had to be in a certain type of building during the telehealth interaction and it was usually a healthcare setting like a hospital, clinic, doctor's office. There are some specific exemptions for the home where the services can take place in the home underneath the permanent Medicare telehealth policies, they were very specific.

Fast-forward to the pandemic. Suddenly for one thing it was a highly contagious disease so people were trying to make sure the contact was limited, and one way of using telehealth to cut down on that sort of in person interaction and not potentially expose people more to COVID-19 was using telehealth. That became a great tool for the healthcare system in order to continue to provide services to patients, but limit sort of the potential for being infected by COVID 19.

However, the Medicare policies, as I mentioned earlier, permanent ones were limiting and how you could use it. The federal government instituted waivers to allow telehealth to be used more widely.

The waivers had to be done by Congress. This wasn't something that CMS, for the most part, could do on their own because a lot of the permanent telehealth Medicare policies are in federal statute. That is why we have always had to say, we got to wait for Congress to act because there's only so much CMS can do themselves.

Anyway, go through the waivers in the pandemic and the public health emergency for COVID-19 is ending and then Congress extends it out. The waivers themselves out pretty much intact for the most part. Deftly for the major ones invented in federal statute. Through the end of 2024. December 21, 2024. As we were coming towards the end of last year there was concerns of our we going to have an extension and what is it going to look like if we do have it or are the services going to be abruptly cut off? As most of you know right now the extension was done. It was done in the continuing resolution, which is not a telehealth stand-alone bill. It's an appropriation bill to keep the federal government funded for a period of time.

There was no standalone telehealth bill, it was something placed in a larger bill and that's kind of been sort of the trap that has happened over the last couple of years stopped telehealth there has been a standalone telehealth bill to address policies and Medicare. They've usually been embedded in a larger bill. This was in the continued resolution. Only problem is a continuing resolution was only for three months and the three-month extension also apply to telehealth as well.

Now we have a new end date for the telehealth waivers of March 31, 2025 which as of today is a little bit

more than two and half months at this point.

We are kind of back where we were basically in November or December as we are waiting to see what would happen with the extension with a certain twist on that. I'll get to that in a second. Basically this is what it looks like. Waivers included geographic requirement. Were talking about earlier requirement that continues to be waived. List of eligible providers again underneath current medical telehealth policy. A specific list of providers that can be the only ones who can provide telehealth services, and have it covered and reimbursed by Medicare. That was expanded during the pandemic and that list is also continuing to be in place or allowed until March.

The site limitations, the actual building the patient is located in basically opening up the home allowing services to take place has also been extended.

Allowing audio only services to take place. I have an*here because gets complicated. We got questions of people have been confused. Audio only has never been just widely used to provide any services and Medicare coverage. Medicare CMS has always had a specific list to say, what's these particular services you can use audio only for. That is going to continue as well with one twist that I mentioned earlier, and again I will get to that in a moment.

Then the delay of the in-person requirement before a mental health service can take place in the home. For those who may not be familiar with this or maybe confused underneath permanent telehealth Medicare policy there is an exception to the site location such as we need to geographic requirement in allowing sources to take place at home for mental health behavioral services.

If there is a prior in person visit with the telehealth provider no later than six months before the telehealth services plate place. That's the in-person requirement. There are other exceptions for services taking place in the home including one for mental behavioral health, but that one is attached to you have to be concurrent with the diagnosis of a substance or opiate use disorder. Those other exceptions do not require a prior in-person visit. This is only if you are doing other types of mental health services in the home and you are also not meeting that geographic requirement. That's when you have to have that in person visit, prior in-person visit take place. That has actually never been implemented and when they put that into federal law and this is a federal statute as well. When Congress put that into law it was during the first year of the pandemic. December 2020. But it was never instituted because we've always been since it was put in federal law underneath this waiver state with telehealth policy. It's never been implemented and won't be until we are actually kind of out of this waiver state here. But it is something that is there in federal law.

However, again, it's been waived through March 31 of 2025 currently. The slide shows a couple of other

things that were not necessarily touched upon by Congress because these are things that sit squarely underneath CMS's purview to decide on what they are going to do with it. Some of these things are pretty hyper specific. For example, allowing practitioners to continue to use their business address as where they provide telehealth services even if they may have been working at home. That was an issue that arose during the pandemic and was a concern long before that, but it really became a promise when telehealth was used more widely with concerns of some of that information can be publicly accessible so that made some practitioners and-- uneasy with that. They are keeping that until the end of 2025. Also underneath permanent Medicare telehealth policies frequency limitations and how often you can use telehealth is in certain locations such as skilled nursing facilities. CMS is waiving that frequency requirement as well too.

Couple of other things. The one thing that is kind of a hybrid and federal law but really CMS has more control over it is the list of eligible services. Basically why say it's in federal law is because in federal law they're basically trying to give a base saying well at least the services need to be covered if telehealth is used. But then they also have additional language saying and any other services that the secretary of CMS decides they want to add to the list, so that's why it's a little bit of hybrid. In statute there is a base but really kind of the power is in CMS hands at this point. As far as adding new services because the law only requires a base level of things to happen there as well too. That was kind of like a little bit about why it's not clearly separated out of Congress controls, CMS has control type of thing.

What are some of the frequenting asked questions and why have I been eluding to? There's kind of a twist on things on why there may be some confusion based upon the extension of this additional three months that Congress did. The reason is you have to understand the timing of things happening here.

Usually when policy happens it usually starts a lot of times with legislation. A law is passed and then it goes to the law as fast put on the books and then like regulatory agency or administrating agency, whatever agency or department is overseeing the particular law and its implementation and enforcement they do regulations. For those who aren't familiar with it sort of like very briefly that process is the write up regulations. They send them out for public comment, taken the public comment and finalize them.

Then we go to the other sort of third element of developing policy that I mentioned earlier, guidance and letters if there needs to be additional clarifications on what they meant by the regulations or additional details they want to add. Usually this works fine. Kind of like the process that we've gone through with any type of law. Laws, regulations and clarification from agencies themselves later on.

However, what happened with the telehealth policy here is that you have Congress taking action here, CMS taking actions through the physician fee schedule like they did in 2024 and that was for 2025, and the timing is off. Some of the policies are not quite aligned. Instead of like this they are a little bit off line a

little bit and that is causing I think confusion for some folks as well. The reason for that is this is how the timing usually works.

CMS has a fairly established timeline of when they need to do their physician fee schedule. I think they actually start immediately after the previous one had been finalized. Like late in December where they start cracking and developing what policies are going to be introduced for the following year. For next year. For our physician fee schedule for 2025 they were probably already starting work on that in December 2023 so they have to start work on that, develop proposals and everything and then go through their internal process to get it vetted, checked over and come back and etc. and then they publish them usually in July.

They post them for public comment and then they allow 60 days for the public to make comments and send feedback on those proposals and their required by law to have that public comment period. They taken those comments after the deadline for the comment period and then they have to again, by law, respond to all of those comments and make any adjustments they may want for their final version of those proposals, and those proposals are usually published.

For the most part CMS has stuck to it. Since I've been doing this may be one or two occasions where they were a little bit late, like the final version might have been published in early December and things came out very late in July as opposed to kind of more at the beginning, but for the most part CMS has to stick to this because a lot of it is required to by law because of the public comment period, etc. needing to respond back to the comments. You have the timing here for CMS that is pretty set.

Congress does have pretty set deadlines imposed on them as well such as they knew the telehealth waivers were expiring at the end of the year, so they knew they had that deadline, but they didn't have sort of this really set out deadline of, or milestones or timelines that CMS had.

All this to say is that when CMS was developing their 2025 physician fee schedule proposals the only information they had to work with that they knew about with those telehealth waivers was that they were expiring December 31, 2024. They had to work with that information and they had to develop proposals accordingly. That is why the CMS proposals seem to take into consideration that the waivers have expired come January 1 because that was all that they knew when they were going through their timeline doing this. That's why when Congress did act and I will remind people Congress did not fully pass waivers until, and it was signed by the president, December 21, 2024. We got very close to that deadline.

That's the reason why you have a little bit of not quite alignment on some of the policies from the physician fee schedule that CMS put out for 2025, and now this extended three month period. While

showing an example of that.

Congress, as I mentioned earlier, they said the eligible provider list and it will continue through March 31, 2025. That still in play here. CMS with their physician fee schedule cannot add practitioners or eligible providers onto the eligible telehealth list. However, what they said was, in the 2025 physician fee schedule is while those federal laws have specific list of practitioner that they made an telehealth policies are meant to apply to those practitioners. That leaves us free to develop policies for folks that are not on those lists such as institutions like if QAC's and RHC's.

They did this a couple of years ago for opioid treatment programs. They applied the same logic for both of these and what they said in the physician fee schedule for 2025 is that we will continue to allow both of them to use telehealth to provide services until the end of 2025. Right there you see kind of a misalignment on the policies because, again, CMS was operating under the knowledge that they had at the time that the waivers could potentially end December 31, 2024. What was in their power as they extended it an additional year.

This is not a particularly major discretion or anything or conflict because this is like a policy overlapping each other. This doesn't make too much of a difference. They're both saying at least March 31, 2025 we can continue to use services under telecare and continue to get reimbursed. It's just kind of like an overlapping policy. It only becomes important if nothing is done about the March 31 deadline and then the waivers and. CMS has a policy in place for nine months. This is like a case where it's overlapping it's not too big of a deal here. There's not too much of a wait what are we supposed to do kind of question that comes up with this particular policy.

However, where there is more confusion, we have emails about this regarding audio only. What's covered by audio only now? I mentioned earlier that during the pandemic were audio only was concerned CMS has never done a blanket, you can do anything via audio. It says no you can only do certain services and audio only and we will pay for that.

What happened is that underneath the continuing resolution what Congress did was they just said you can continue to use audio only. This is the language that's actually in there. If you look at that language, again they don't really explicitly say the services. They refer back to the base level of services in federal statute and saying whatever the secretary kind of wants to do. Again kind of leaving a lot of power in CMS's hands on what audio only service is full stoppages have to make sure there's that base level.

But for the 2025 physician fee schedule CMS said we are deleting the audio only codes 99441299443 and the reason for that is the AMA which does do the CPT code sort of thing were deleting that and seamless was mirroring their policy as well.

Also the reason they were doing that, again, they were operating underneath the information that they had at the time which was the waivers were expiring. When the waivers expire the only way you could use audio only was with provision of mental health services based on other policies that were in place under permit telehealth policy. The CMS policy they have now, especially eligible telehealth services list which is available, 2025 version, that's the link you can click on and pull up that list, you will see 99441 and 99443 as the lead in on that list. For audio only you will see some mental health services that are listed on there you can use in code.

This is where you have these two tracts of policymaking where they are sending out a misalignment. Unlike the other where there is an overlap and it's not too big a deal there were the deadline happens and nothing happens on the congressional side of things it's kind when it kicks in. This is where you see it's a little bit like not align with each other.

The question is, do we do 99441, 99443, to still have that available to bill or do we use something else and maybe put a modifier on it to indicate we did the audio. What we do now? The answer to that is we are not sure.

CCHP along with a couple of others have submitted questions to CMS a saying what do we do now because of this three-month extension here. Do we still use these codes or do something else? CMS is aware of that and they say they will get back to us, but I don't have an explicit answer for you right now, but wanted to point out this is where you start seeing the kind of misalignment of the policies where they were operating on two different tracks and one was operating with certain information they had at the time were they developed more information and they just quite our meeting at here. It's going to take CMS a bit of time to clear up some of these sort of slightly offkilter, not quite aligned up policies as well too.

We've also gotten questions of what happens if the March 31 deadline happens and nothing is done by Congress. We go back to permanent telehealth policies. What that means is those geographic limitations come back into place. There's exception there for stroke and stay at your renal disease and some mental health services. If certain conditions are met eligible originating site facilities, goes back to that restricted list, it has to be some sort of healthcare facility and they are specific about what type of facility. Again limited exceptions for mental health services substance use disorder for those mental health services they can take license at home. Limited lists of eligible practitioners and exceptions to that. When we talked about earlier.

Audio only reference. That's gone from the statute. It will be limited again in the mental health services taking place at home that I talked about earlier that required in person visit prior to those mental health

services taking place in the home, if you're not in geographic restriction or its not a co-occurring mental health disorder, or you've been diagnosed and been treated for substance use disorder that will also take place as well.

Here are a couple of things where CMS created exceptions to the policy. We talked about it earlier. Audio only, that is literally gone. If the March 31 deadline happens the audio only sort of allowing it for telehealth the language doesn't completely disappear from the statute, basically the policy does. CMS has sort of read through their powers of being able to define certain things allowed audio only to be used for mental health services. Now also what happened in the 2025 physician fee schedule is they expanded this definition for audio only until a communication services to allow other services to be provided via audio only, but the created certain conditions on that.

One of those conditions was that the services had to take place in the home. This is where you need to cross-reference your policies. It says it sounds great audio only is used for other services under the permanent Medicare policies, great that opens up a whole window there. Wait a minute. However the patient's needs to be at home what other services need to take place at home. Limited. End-stage renal disease. Certain mental health services. It's not as extensive as you may think. It is definitely continuing to allow audio only services rather than just completely cut it off there.

Then we talked about the in person requirement. Keep in mind the prior in-person requirement is taking place in the home, not meaning geographic requirement there. There needs to be a follow-up every 12 months, another in person visit every 12 months. They created an exception to that if the provider and patient determined it would be detrimental to delay those telehealth services as you try to get that in person visit done.

These are, again, sort of like the interactions of where policy happens. What I was talking about earlier where you have the law passed but then you have the finer details being fleshed out through regulation that's kind of like with this is as well. Sometimes that helps it and makes it a bit more expansive, other times that's like an additional detail that might make it a bit more complicated as well.

Audio only, I wanted to just put out that this is what CMS wrote and wanted to point out that it is very specific and says the beneficiaries in the home to remember what our service is going to take place in the home talking about medic to locale fare policy. I want to emphasize that in case people are confused if there think about a change the definition allows for a broader set of services to take place in the home we went to permanent Medicaid-- Medicare telehealth policy. The audio only like more services in the home. It doesn't because of the limited set of services that can take place in the home underneath Medicare permanent telehealth policy.

I know it's confusing because we go back and forth between permanent and the waivers, but this is how it is set up right now.

Prescribing substances. This is federal telehealth policy that people may have questions about. Again sort of like the timeline. For those of you not familiar with it prescribing controlled substance telehealth policy Congress actually did not do anything about that during the pandemic because the policy was already in place and federal law.

And federal law were telehealth is concerned there's a certain section underneath the prescribing of controlled substances that specific telehealth, there are certain exceptions in place and they existed before the pandemic. Basically the exceptions and where you can use telehealth to prescribe controlled substance without the telehealth provider having an in-person exam of the patient before prescribing via telehealth is where cases and exceptions are sort of like when the patient is with another DEA register provider during the time of the had telehealth interaction with rented DEA register facility. A lot of the narrow exceptions that a lot of telehealth is used with the prior in person visit is basically the patient with somebody, some sort of healthcare professional at that time of the interaction.

One of the other exceptions when a public health emergency is declared, that's why this kicked into place when COVID-19 happened. Again, like with the Medicare waivers, when Public Health Emergency Leave was winding down there was concern of what about the prescribed and controlled substance. Healthcare is all linked with each other so what's going to happen here. I think probably a lot are aware that the DEA was going to create sort of like a hybrid kind of extension there and do other sort of requirements. It did not go over well before the pandemic ended. The DEA extended out for about a year the telehealth waivers that were mirroring what happened during the pandemic, and then through various other issues that happened and everything essentially they lined up when the Medicare waivers went so they had a deadline as well of December 31, 2024.

However, the DEA in November 2024 did issue one year extension of the waivers as well. We have gotten questions of people who may not have heard that but that happened November 15 of 2024 where they did issue that extension and that is the link to that if anybody wants to read the Federal Register there's an admission for that as well too.

What's going on on the state level? Basically some folks have asked all the stuff going on with Medicare on the federal level is that going to impact me on the state level. I don't have Medicare patients but I see commercial patients. I use telehealth. Can I still use it? All of that know.

The Medicare waivers impact the Medicare program. If you are practitioner and all you have are Medicaid patients for the most part those Medicare waivers are not going to impact you directly, and I'll

explain why I'm saying that and putting that caveat in there. Essentially the Medicare waivers do not impact you if you are not providing services to Medicare enrollees.

Medicaid, commercial payers to have their own telehealth policies themselves and for the most part both the commercial players and the Medicaid payers have already settled on what they are doing. I think one or two states, maybe three but I think there's only two. Two states have also done temporary extensions. There little bit further out so unlike March 31, first they were aligning themselves to what the feds were doing but then the states went off on their own ended their own sort of extension timelines, but practically every other state except for those one or two states have settled on what the telehealth policies are.

So, what's going on with Medicare will not impact that. The one sort of caveat on that is could a Medicaid program eventually copy what Medicare is doing? Yes. That can happen, however it's not going to be an immediate effective March 31 happens, Congress hasn't done anything, deadline hits and waivers expire. It's not going to have the immediate impact like that. They will go through their own process internally and maybe if they do it through regulation so have to do the regulatory process. The left wait for the state legislature to pass something. It's possible they could mirror the Medicare policies, for the most part states are deciding what they're doing around telehealth so they are not changing anything to align themselves with Medicare. They may be making changes and some may reflect the same thing as Medicare, but they are on a different time track as well as they are going to be doing that.

A good example of that is some states are adopting some more of those communications technology-based services such as a consult, those codes within their Medicaid programs, they are on different tracks. If you are not Medicare and you don't have patience on Medicare you got to pay attention to what your state or private payers are doing regarding telehealth policies and a lot of them have that settled. However we are at the start of a new year. This is where a lot of state legislature start coming up with legislation and regulations come out so I highly recommend that CCHP website because there's a particular state you're interested in you can click on that to pull up that information as well.

That's about it. This is the newsletter we have so we can keep up-to-date on things that are happening or developing on the telehealth policy front. We also have our website where we track what's going on in all 50 states Stephen look at that as well, and we also have an email address if you have more specific questions that you want to send to us.

I also have an appendix on here with some resources that go a little bit deeper. This is website stuff such as the fact sheet on our physician fee schedule if you want to dive deeper on what that is there. I do believe, Ari, that they do get a copy of the presentation as well so don't worry about taking pictures or screenshots. You will be able to access the PowerPoint later as well.

We have 20 minutes and I will also apologize right now to the captioner if I was going too fast. We have 20 minutes and I will try to answer as many questions as possible. How is commercial insurance handling this? It's going to depend on each commercial payer. Also depend on what state they are in because some states have statutory policies that impact commercial insurance companies and how they handle telehealth so you need to go look at what they say.

Not all states do this but we are seeing more stop not all states are requiring health insurance companies to pay the same amount, payment parity, although we see more of them do that now than before the pandemic. It's going to proof end-- depend on the state.

You also to keep an eye on it because they may go in and tinker with the policy so you have to see if they introduce legislation on there as well.

Will CMS pay any different for telehealth done audio only? At this point there does not seem to be any indication that the payment amount would be different, but we are still trying to figure out do they still want practitioners to use 99441499443 or will be something with a different code with a modifier. That's like a question. That's where you can possibly see a price difference. I don't remember what exactly was the amount paid for 99441 or 99443 with say CMS says those codes are deleted and were not going to keep them around but we will use Xcode and use a multiplier. The question is what will be the payment amount for the Xcode. That's still up in the air.

Hopefully as I said they did not respond to her question about what are we supposed to do if audio only. We got your question and we are working on it now so hopefully we will get an answer soon.

There are so many questions here. Related to mental health telehealth. Does this include all providers include pharmacists, or only metal health specific providers? I'm assuming you're talking about Medicare. The Medicare eligible telehealth provider list for this three month temporary period basically was whatever eligible tillable-- telehealth provider Medicare provider it is there and so it's all Medicare provider. Who can bill for that particular eligible code?

The question is going to be, first are the pharmacists like a knowledgeable Medicare telehealth provider, and then can they bill those codes that are eligible and that telehealth list. It's a two-step process for them and I'm not sure exactly. I'm not sure pharmacists concluded that eligible Medicare provider pool, and then if they are able to bill on specific codes on the telehealth list. You are going to have to look and see if that is true. If they are an eligible provider the congressional waiver when we expanded it to an eligible telehealth provider, but they also have to be a provider who can build those telehealth, eligible telehealth service codes as well.

There has been questions on how Medicare defines patient home. Does this mean the residential address, the worker address or provider office? CMS did say a couple of years ago when the in person mental health, prior in person mental health visit happened where they said it's the residential address whatever they consider that to be, and it could be something such as the home like what most people would think of home but also it could be like a nursing facility as well, or a temporary shelter as well. They did not say work though. I don't believe they said work so something like that would probably not work what they did expanded out from what most people would think about as home to include those other types of facilities or locations where people may need to have temporary shelters while they did allow those to be part of the definition of patient home.

Two health and behavioral assessment codes count towards the tele-mental health in person requirement? Thank you. The prior in person visit requirement, CMS also clarified that a couple of years ago. They said that it has to be a visit that was covered by Medicare or would have been covered by Medicare had that patient had Medicare coverage at the time of the visit. So, if these codes that you're talking about if they are something that's covered by Medicare and use that to meet your prior in person visit requirement that should work. CMS did, and this is again where you get clarification from CMS. All the law says there had to be a prior in person visit and then they got a little more specific and said, yeah that prior in-person visit has to be something that Medicare would have paid for if had better coverage of the time.

If those codes are codes Medicare would have covered that should make that requirement there. You just got layers of the policies. Regarding tele-mental health have providers asking if the in person visit must be with the same provider, same specialist of the PC. Haven't found any official resource please, thank you.

This one I am going off memory. I think you can still be in the same provider group for the most part has to be with that provider. Has to be with that telehealth provider and that's kind of been the trip up when the policy was put in place that the prior in-person visit policy was put in place that makes it difficult and there's a distance between them. For the most part it does have to be, I want to say it has to be the telehealth provider. I can't remember if there was some sort of exception I thought for if they were in the same group, but don't hold me to that.

This prior in person visit thing is not possible.-- Popular, it's never been instituted but there's also some congressional members who don't like it some hoping at some point Congress maybe takes it out of there.

These codes are deleted and are played by CMS Patel health services will be paid nine and 92 and 993 of Medicare. We are trying to confirm that. Does the thought we had as well but we wanted to confirm

that with CMS and that may be what the route that they take and that's what I was saying it would possibly be another code and you have put them on quickly and to know they have done it via audio only.

You just mentioned that the in person requirement was waived for opioid use or substance use. Can you tell when that happened. I understand what you're talking about.

It's not that it was waived. Again, this is you have to understand this is a timeline of telehealth policy developing here. There were exceptions granted to certain services taking place in the home and not in healthcare facility, and you also didn't have to meet the geographic requirement. Those exceptions, back in 2019 or something like that in the fee schedule, and those exceptions, a note was the statute as well, it was pre-COVID and those exemptions were for end-stage renal disease and substance use disorder treatment and for mental health services if you were being treated for substance use disorder.

Those particular services do not require that in person requirement there. That's where you don't have to do the prior in person visit six months before for those mental health services and issues ordered there.

Part of the reason that happens is because if you're going to be treated for opioid use disorder, substance use disorder, some point you would have seen the provider in person, and also keep in mind this policy was in place prior to COVID-19, so maybe it's a little different now where telehealth was able to be used more expansively but when they did the policy it was before COVID-19, with equally had that in place definitely for end-stage renal disease you would have seen some practitioner beforehand. In person. That's where the exception comes in.

That something that was in place before the pandemic, before the waivers and all the other policies that have come up as well.

Next question here. There are 90 questions here. I will try to stay on as long as possible. Mental health treatment. Willie in person initial visit be extended through 3/Tony five. That waiver is extended through 3/25, marshaling first 2025. What happens afterward we have to wait for Congress to see what happens.

Please mental health exception when the prior person please and doesn't apply. I'm going to skip this. We got over that several times. And is temporarily on hold until March 31. We will have to see what Congress does next.

Can you speak to private payer billing and any action that might require parity? For the most part private payer billing will be left to the states have to see fit depends on what state you're in or with the state may

have in their laws. The laws are basically a mandate to do private pay parity, private payers to parity and payment but there's nothing in any state that prohibits them from doing parity and payment if they wish to do so. It's going to depend on the state and what they have on the books and what they may require.

Mental health treatment. We have following inpatients of an in person follow-up visit. That is probably going to be up to CMS. First off, you're not going to have that in person visit unless you're trying to avoid the geographic restriction and it's taking place in the home and you're not slotting into any other exception. That's the first question to ask.

My patient is always going to go in and if Q agency and that's an eligible geographic location there. This is under the exception the waivers and in March and are in permanent policy land. Then you don't need that in person visit because they fit into the permanent policies that are in place meaning the geographic restriction in a healthcare facility during telehealth care interaction we actually don't need that in person visit there.

However, afterwards it will probably have to be an in-person follow-up and you would also need the 12 month. They may give you a pass on establishing that first but every 12 months you do have an in-person visit. That's probably where you would have to do that but it's going to be up to CMS to decide how they will implement that but my guess would be like it's possible they wave the first one, the prior and first and visit before telehealth services started because you're in the midst of it they will probably say that 12 month requirement does kick in. That speculation in this point, we're still in waiver land and that prior in-person mental health visit requirement has never been implemented because we've always been in waiver land.

For any location can we go back to the real facilities? Yes. If we go back to permanent telehealth policy land that's gonna kick in as well with all of these exceptions we talked about. The requirements for Medicare patients and in-person visits for the same Medicare management with straight Medicare?

Here's the thing. The telehealth restrictions that we see for its original Medicare, that's like the fee for service stuff. That's kind of like the baseline. Medicare management actually has more flexibility in what they can do. I actually don't think they need that prior in person visit because they've always had the flexibility to be in the originating site there. I'm not sure there going to require that with the managed care plans as well. It's kind of like a little bit of unknown territory to extend that requirement out there.

My guess is I want to say no because the Medicare has always had or is not always, but over the last couple of years even before the pandemic have had a lot more flexibility in how they use telehealth then what's in federal statute that applies to regional fee-for-service there.

Since that policy has never been implemented I don't know CMS is going to take a different path on that. It might be a weight and sees type of situation.

I noticed the RFC of Casey may still use a CFS modifier for the same telehealth services. (indiscernible) can you answer (indiscernible) 2025. If so do you have a scenario just for F or Cuyler a literacies and RAC's. I thought they were supposed to use FQ but I can't remember that offhand. Jody, we will have to get back to you on that.

We are probably going to have to get back. If you wouldn't mind emailing me that particular question, and aria can you put my email address in the chat just so I can follow up on that. I thought they were only supposed to use FK but I can't remember offhand.

Our marriage and family therapist allowed to see Medicare patients? They are on the eligible telehealth provider list. They were put on there in 2023 I think. They are on there already. If the waiver expired they should still be OK.

Medicare did require (indiscernible) which should we use now? Requirement we are waiting for that trying to see what CMS wants everybody to do regarding audio only.

Is there any single source for my state to obtain the billing guidelines for each payer (indiscernible) all have their own policies. Probably not. Some of the telehealth resource centers have writable that together. One of the biggest problems were Medicare and Medicaid are little bit easier because they make that publicly accessible. A lot of commercial payers may not make it readily available to the general public only to like their practitioners.

I would say the best shot is we deftly do not have that information for commercial payers is check their telehealth resource centers. A couple of them have been able to pull some of that information together but they are probably the best place to see if they may have that commercial payer information, or if they know where you may be able to get that. But you are going to have to go state-by-state and for commercial it will be payer by payer as well.

If the in person waiver is not extended why did any penalty apply for the in-person requirement if not met. That's up to CMS. Again, policies not been instituted yet so we don't know how they will check on it, monitor and what they are going to do with it.

Guessing this questions for the end of the session. Ken provider still use 99241 with (indiscernible) established patient codes.

Check the telehealth services list, the 2025 version is out and the link is in the presentation so you can search for it on Google. Medicare telehealth services list. That will pop up or you can have the link available in the PowerPoint as well for

(indiscernible) or should we continue to bill under PFS rules?

This is one of those things that may need to be clarified by CMS where, as I mentioned, as CMS was doing their physician fee schedule they are operating under the information they had at the time which was that the waivers would expire at the end of the year and that's probably another sort of detail they will need to clarify as well.

Will there be exceptions to the in person requirements such as wheelchair-bound? I mentioned the exception which was that if the patient and the provider's believe that it would be detrimental to delay that but other than that I haven't seen of any other exceptions, but again that prior in person visit policy has not been implemented so we are still not person=-- certain what's going to happen or how they are going to institute it once becomes act.

I know aria wants me to get off. Think needs the system back. If you could just download those other questions for me I could take a look at them and try to get back to folks as well.

ARIA JAVIDAN:
For those questions we didn't get to I will record and send them over to in the team. If you have further telehealth policy you can submit them. See CAHP.org. Just a reminder that the next webinar is going to be next Thursday, January 16. Posted by the Atlantic telehealth resource Center on the digital health readiness screener.

The survey will pop up at the conclusion of this webinar is the feedback is valuable to us. Thank you again to the Center for Connected Health Policy for hosting today's webinar and to Mei for her presentation. Have a great day, everyone.

MEI KWONG:
Goodbye, everyone.

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