Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center
TeleBehavioral Health 101 Training Series

Behavioral Health Telehealth Resource
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Email: melmckee@uw.edu

Behavioral Health Institute (BHI)
Training, Workforce and Policy Innovation Center

The Behavioral Health Institute (BHI) Is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment. The BHI established initial priority programs which include:

- Improving care for youth and young adults with early psychosis
- Behavioral Health Urgent Care Walk in Clinic
- Expanded Digital and Telehealth Services
- Behavioral Health Training, Workforce and Policy Innovation Center

WEBINAR LOGISTICS

CHAT

- Logistics
- Technical issues
- NOT for content-related questions

Q & A

- Content questions

TeleBehavioral Health 101 Series

TeleBehavioral Health 101 is a 6-module online series as follows:

- Session 1: TeleBehavioral Health Overview and Policy*
- Session 2: Getting Started: TeleBehavioral Health Myths, Facts, Security, & Privacy
- Session 3: Getting Started: Do’s & Don't's, Workflows, and Safety Planning
- Session 4: Billing & Reimbursement for TeleBehavioral Health
- Session 5: Clinical Engagement over Telehealth
- Session 6: Clinical Supervision in Telehealth

*Please note that Session 1 meets Washington State SB6061 training requirements (effective Jan. 1, 2021) for clinicians providing telehealth services.

DISCLAIMER

- Speakers have no relevant conflicts of interest to disclose.
- Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.
- Federal and state policies change frequently.
- Always consult with legal counsel.

DISCLOSURE

Planner Disclosures:

The following series planner have no relevant conflicts of interest to disclose:

- Melody McKee SUDP MS
- Cara Towle MSN RN MA
- Kimbo Smith MA Med
- Bradford Felker MD

Speaker Disclosures:

- No speakers in this series have any reported conflicts to disclose.

We gratefully acknowledge the support from

and

TODAY'S SPEAKERS

Catherine Britain

- Executive Director of the Telehealth Alliance of Oregon (TAO), an organization she helped found in 2001.
- Board member, Oregon Rural Health Association
- Board member, Northwest Regional Telehealth Resource Center.
- Founding Program Manager for Rodeo Net, one of the first telebehavioral health programs in the United States.

Michelle Martinez, MPH

- Behavioral Health Telehealth Program Manager at Health Care Authority
- Previously worked in clinical psychology research, focusing on mindfulness- and meditation-based therapies for veterans with PTSD at VA Puget Sound.
- Co-author, chapter on PTSD in the 4th Edition of *Integrated Medicine* and several journal articles appearing in the *American Journal of Medicine, Medical Care,* the *Journal of Clinical Psychology,* the *Journal of Alternative and Complementary Medicine*, and the *Journal of Traumatic Stress*.

TELEHEALTH REIMBURSEMENT BASICS VIDEO

CENTER FOR CONNECTED HEALTH POLICY

BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH:

TeleBehavioral Health 101

BILLING & REIMBURSEMENT FOR TELEHEALTH - MEDICARE

Catherine Britain, Consultant

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LEARNING OBJECTIVES

- Understand telehealth reimbursement funding and criteria for reimbursement
- Distinguish which types of telehealth services are eligible for reimbursement
- Identify the main modifiers and other codes used to indicate a telehealth service
- Identify resources for policy updates, particularly when the PHE-specific policies (relaxed regulations) no longer apply

A Word about the COVID-19 Public Health Emergency (PHE)

- The PHE for the Coronavirus 2019 was first declared at the Federal level on January 31, 2020, by the Secretary for Health and Human Services.

- It is currently extended until April 21, 2021, at which time it is likely to be extended by the new Administration. (The PHE was recently extended to through December 2021.)

- All of the relaxations that have been made to the federal telehealth rules will expire when the PHE ends unless statutes or regulations have been permanently changed by Congress or CMS.

- Because policies can change frequently during this time, always check the published date of any policy information that you read to be sure you have the most current material.

How Medicare Statutes are Created

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- A statute is a written law passed by a legislature on the state or federal level.

- Statutes set forth general propositions of law that are applied to specific situations. A statute may forbid a certain act, direct a certain act, make a declaration, or set forth governmental mechanisms to aid society.
  https://legal-dictionary.thefreedictionary.com/statute

- Congress creates the laws that govern Medicare. Only Congress can change these laws.

How Medicare Regulations Are Created

- Regulations add guidance, management, control, or disposition to laws.
- The Center for Medicare and Medicaid Services (CMS) establishes the regulations for most of the telehealth laws/statutes that are passed by Congress.

Regulations during the Coronavirus PHE
The Cares Act

On March 27, 2020, Congress passed the Coronavirus Aid, Relief, and Economic Security (CARES) Act (H.R.748), in response to the COVID-19 public health emergency. It signaled strong support for the use of telehealth and virtual care and created flexibilities for previously created telehealth laws. Congress directed CMS to develop regulation/guidance for these flexibilities.

Regulations during the Coronavirus PHE The 1135 Waiver

- When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to his/her regular authorities. For example, under section 1135 of the Social Security Act, he/she may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse)

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/1135-Waivers-At-A-Glance.pdf

Medicare Reimbursement Regulations For Telehealth

Medicare reimbursement regulations for telehealth fall into seven categories or "buckets".

- ✓Provider/patient location
- ✓Eligible providers and facilities
- ✓Types of services
- ✓Billing, payment, and coverage for telehealth services
- ✓Prescribing controlled substances
- ✓HIPAA
- ✓Stark Laws

Medicare Reimbursement Regulations For Telehealth

- The first four "buckets" will be covered in this presentation. The last three have been covered in previous presentations and will be included in the resources provided at the end of the presentation.
- Each "bucket" describes the statute or regulation before the PHE, the action taken during the PHE, and the action needed to make the change permanent following the expiration of the PHE.
- Unless an action taken during the PHE is made permanent either by statute or regulation, the action will expire when the PHE expires.

Bucket #1
Provider/Patient Location

<u>Providers at home</u>

- Before the PHE: providers providing services from their homes were required to update their Medicare enrollment to include their home location. Their clinic group practices were required to provide updated information if the provider had assigned his/her benefits to the practice.

- During the PHE: no update is required.

- CMS could choose to make this guidance permanent under its regulatory authority.

Bucket #1
Provider/Patient Location

Geographic and originating site requirements

- Before PHE: Providers were reimbursed for services delivered to patients that were presented in an originating site located in a CMS defined rural area. The type of originating site had to be approved by CMS. Patients could receive services in their homes only for end-state renal disease, acute stroke treatment, and substance use disorders and co-occurring mental health disorders.
- During the PHE: Providers may deliver telehealth services to patients in their homes and other locations, and in any area of the country. CMS encourages states to relax their licensing laws.
- Congress will need to pass legislation to expand pre-COVID law to include the expansions allowed during the PHE.

Bucket #2
Eligible Providers and Facilities

Additional Practitioners

- Before the PHE: CMS limited the types of providers that could bill Medicare for telehealth services to:

Physicians	Clinical nurse specialists
Nurse practitioners	Certified registered nurse anesthetists
Physician assistants	Clinical psychologists and social workers
Nurse midwives	Registered dietitians or nutrition professionals

- During the PHE: All health care professionals who are eligible to bill Medicare for their services may deliver and bill for services provided via telehealth.
- Congress could expand the list of eligible providers or give the HHS Secretary authority to determine eligible providers.

Bucket #2
Eligible Providers and Facilities

RHCs and FQHCs

- Before the PHE: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) could only serve as originating sites for the provision of telehealth services.

- During the PHE: RHCs and FQHCs may serve as distant sites for the provision of telehealth services.

- Congress could make this change permanent.

Bucket #2
Eligible Providers and Facilities

Hospital Outpatient Billing for Telehealth

- Before the PHE: This was not allowed prior to the PHE.
- During the PHE: Hospitals, including Critical Access Hospitals (CAHS), may bill the outpatient perspective payment system (OPPS) or otherwise applicable payment system for therapy, training and education services furnished remotely by hospital clinical staff to Medicare patients registered as hospital outpatients, including when the patient is at home.
- Congress could make this change permanent or grant the HHS Secretary the authority to determine which providers may deliver and bill for these services.

Bucket #2
Eligible Providers and Facilities

<u>Direct supervision</u>

- Before the PHE: Direct supervision of covered services had to be performed under the general in person supervision of a physician or a non-physician practitioner.
- During the PHE: Supervision may be provided using real-time, interactive audio and video technology.
- CMS will allow direct supervision to be provided using real-time, interactive audio and video technology through the end of the calendar year in which the PHE ends or December 31, 2021, at which time it will be reviewed and could be made permanent.

Bucket #3
Types of Services

Audio-only communication

Before the PHE: Providers were required to deliver telehealth services through two-way audio and video communication.

During the PHE: Providers may deliver certain Medicare telehealth services via audio-only communication.

Legislation is required to either codify in statute that telehealth services may, in certain instances, include audio-only communication ; or lawmakers could grant the HHS Secretary the authority to allow certain services to be delivered via audio-only communication.

Bucket #3
Types of Services

<u>Additional Telehealth Services</u>

- Before the PHE: CMS provided payment for nearly 100 telehealth services when furnished via telehealth under the 2020 Physician's Fee Schedule.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

- During the PHE: More than 140 additional telehealth services were added to the list of services that could be reimbursed by CMS and allowed additional services to be added on a sub regulatory basis to the list of Medicare telehealth services

https://www.cms.gov/Medicare/Medicare-general-information/telehealth/telehealth-codes

Bucket #3
Types of Services

Additional Telehealth Services (cont.)

- The 2021 Physician's Fee Schedule made some of the codes allowed during the PHE permanent and created a list of codes that were placed in a third category (Category 3). These services "include codes in the list that were added during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. Category 3 services would remain on the Medicare eligible telehealth services list through the calendar year in which the PHE ends. To become permanent, they would need to meet the qualifications of Category 1 or 2 ".

https://www.cchpca.org/sites/default/files/2020-12/CY%202021%20Medicare%20Physician%20Fee%20Schedule.pdf

Bucket #3
Types of Services

Virtual check-ins and E-visits (not considered telehealth by CMS and are referred to as Communication Based Technology Services – CBTS)

- Before the PHE: Virtual check-ins and e-visits could only be provided to established patients.
- During the PHE: Virtual check-ins and e-visits can be provided to both new and established patients
- CMS clarified in the 2021 PFS that clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists may also provide and bill for these services to established patients

https://www.cchpca.org/sites/default/files/2020-12/CY%202021%20Medicare%20Physician%20Fee%20Schedule.pdf

Bucket #3
Types of Services

<u>Remote Physiological Monitoring (RPM) Services</u>

- Before the PHE: RPM could be used for established patients with chronic conditions only.
- During the PHE: RPM can be used for both new and established patients and for acute as well as chronic conditions.
- In the final 2021 Physician Fee Schedule CMS proposed significant changes to the RPM rule including:
  - An established patient-physician relationship will be required
  - Consent can be obtained at the time the RPM services are furnished
  - Acute as well as chronic conditions qualify for RPM services

  Other changes can be found at

https://www.cchpca.org/sites/default/files/2020-12/CY%202021%20Medicare%20Physician%20Fee%20Schedule.pdf

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

Parity of Payment

- Before the PHE: Telehealth services were billed using the payment amount established for telehealth in the Physician Fee Schedule which was less that the rates for the in-person fee-for-service rate.
- During the PHE: Payment is the same as would have been received if it had been provided in-person. Some rates for telephone visits have been increased.
- CMS could use its regulatory authority to make this change permanent or Congress could pass legislation mandating parity for telehealth services.

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

<u>Frequency Limitations</u>

- Before the PHE: CMS imposed frequency limitations on subsequent telehealth visits (in-patient – once every three days; skilled nursing facility – once every thirty days; and critical care consults – once a day).
- During the PHE: All of the frequency limitations are removed.
- In the 2021 Physician Fee Schedule CMS revised the frequency limitation in a skilled nursing facility to once every 14 days from once every 30 days. Other frequency limitations could be changed by CMS under its rule making authority.

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

Part B Facility Fee

- Before the PHE: Hospitals were not allowed to bill the originating site fee when the Medicare patient was registered as a hospital outpatient, but located at home
- During the PHE: Hospitals are allowed to bill the originating site facility fee for telehealth services paid under the Medicare PFS and furnished by hospital providers to Medicare patients registered as hospital outpatients including when the patient is located at home.
- Congress would need to pass legislation removing the prohibition or authorize the HHS Secretary to waive it as appropriate.

Bucket #4
Billing, Payment and Coverage for Telehealth Services

Physical Examination

- Before the PHE: CMS required a history and/or physical examination in order to bill an office or outpatient evaluation and management (E/M) visit delivered via telehealth.
- During the PHE: Visits can be provided for any patient via telehealth and the office/outpatient E/M level selection for these services when furnished via telehealth can be based solely on the level of medical decision-making or time spent by the provider on the day of the visit.
- CMS could use its rule-making authority to make the change permanent.

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

<u>Consent to Treat</u>

- Before the PHE: The annual consent to treat with RPM services had to be obtained prior to the service being provided.
- During the PHE: The annual consent for treatment may be obtained at the same time that services are furnished.
- This change was made permanent by CMS in the 2021 Physician Fee Schedule.

Bucket #4 Billing, Payment, and Coverage for Telehealth Services

Codes and Modifiers

- Before the PHE: When billing for a telehealth encounter the provider was required to use the point of service(POS) code 02 which indicated that the visit was provided via telehealth.
- Before the PHE: FQHCs and RHCs were not allowed to provide or bill for telehealth services.
- During the PHE: Providers are allowed to report the POS code that would have been reported had the service been furnished in person (e.g. POS 11 – office) so that providers can receive the appropriate facility or non-facility rate. Providers should use the modifier “95” to indicate that the service took place via telehealth. If providers wish to use POS code 02, they may, and it pays the facility rate.
- During the PHE: FQHCs/RHCs should use the HCPCS code G2025 to show that the service was delivered via telehealth and to receive the appropriate payment of $92.

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

Codes and Modifiers (cont.)

- During the PHE: The "CS" modifier should be used only when providing a COVID-19 related service.
- CMS would need to make permanent changes to the fee-for-service rules

Please note: Telehealth billing codes and procedures are complex and there is not time to cover them in detail in this presentation. Please use the following resources for more information:

- https://www.cchpca.org/sites/default/files/2020-12/CY%202021%20Medicare%20Physician%20Fee%20Schedule.pdf
- https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Bucket #4
Billing, Payment, and Coverage for Telehealth Services

Out-of –pocket costs/co-pays

- Before the PHE: Telehealth providers were subject to sanctions from the Office of the Inspector General (OIG) if they waived or reduced any cost-sharing obligations that beneficiaries owed for telehealth services.
- During the PHE: The physician or practitioner may reduce or waive any co-pay the beneficiary may owe for telehealth services.
- Changes would need to be made to the Stark Laws and the regulations related to those laws.

Recent Updates

- The US Department of Health and Human Services just announced it will eliminate the X-waiver requirement for DEA-registered physicians. This move is designed to expand access to medication-assisted treatment (MAT) by exempting physicians from certain certification requirements needed to prescribe buprenorphine for opioid use disorder (OUD).

- President Biden announced that he plans to issue a regulatory freeze on the proposed major HIPAA Privacy Rule changes made by the former administration.

Sources

The majority of this information in this presentation is sourced from:

- The Center for Connected Health Policy www.cchpa.org

  https://www.cchpca.org/telehealth-policy/national-policy

- The CMS website https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.

- The American Hospital Association

https://www.aha.org/system/files/media/file/2020/06/fact-sheet-making-telehealth-flexibilities-permanent-legislation-or-regulation.pdf

BUILDING TELEHEALTH CAPACITY for BEHAVIORAL HEALTH:

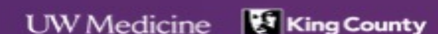
TeleBehavioral Health 101

BILLING & REIMBURSEMENT FOR TELEBEHAVIORAL HEALTH - MEDICAID

Michelle Martinez MPH
Behavioral Health Telehealth Program Manager
WA State Health Care Authority

BEHAVIORAL HEALTH INSTITUTE

HARBORVIEW MEDICAL CENTER



LEARNING OBJECTIVES

1. Understand criteria for reimbursement of telehealth services billed to Managed Care Organizations (MCOs) and Behavioral Health Administrative Service Organizations (BH-ASOs) during the COVID-19 Public Health Emergency (PHE)

2. Identify the types of services that are NOT billable if provided via telehealth

3. Identify the main modifiers and other codes used to indicate a telehealth service

4. Identify resources for policy updates, particularly when the PHE-specific policies (relaxed regulations) no longer apply

4 Elements of Telehealth Reimbursement Policy

1. WHO was the PROVIDER providing the service? *(physician, Behavioral Health facility, FQHC, Rural Health Clinic, Tribal facility, etc.)*
2. WHAT was the service provided? *(psychotherapy, medication management, etc.)*
3. WHERE was the patient located? *(home, a behavioral health clinic, skilled nursing facility, assisted living facility, etc.)*
4. HOW was the service delivered? (HIPAA-compliant real-time audio-video; phone; store-and-forward, etc.)

Telehealth (TH) and Telemedicine Policies

- **Telemedicine:** HIPAA-compliant, synchronous/real-time, audio-video interaction

→ *Health Care Authority is maintaining the tele<u>medicine</u> payment parity that has been in place since 2018*

- **New telehealth (TH)** policies are in effect through the COVID-19 Public Health Emergency (PHE) as "relaxed regulations" to allow remote service modalities that do not meet the definition of "telemedicine" above, such as audio only / phone, and non-HIPAA compliant platforms for real-time audio-video conferencing (e.g. FaceTime)

  Note: Which of these new tele<u>health</u> policies will stay in effect when the PHE is over has not yet been determined. In the meantime, payment parity temporarily applies to these additional service delivery modalities

TIMELINE: PAYMENT PARITY FOR "TELE" SERVICES

Payment parity (equal payment rates) between in-person services and tele<u>medicine</u>-delivered services (HIPAA-compliant real-time audio-video interactions) **has been provided within Apple Health Medicaid since 2018**

In March 2020, legislation passed mandating **payment parity for tele<u>medicine</u> for <u>all</u> <u>payers</u>** in WA

For the COVID-19 PHE, payment parity has been made ***<u>temporarily</u>*** **<u>available for all services in SERI</u>** billed to MCOs, delivered via telehealth that would normally be provided in person.

2020

2018

2021

Under normal circumstances, some remote services, like phone-delivered care, have been billable, but reimbursed at different rates than in-person care

2/29/2020
Inslee declares PHE

CRITERIA FOR REIMBURSEMENT / PAYMENT FOR TELEHEALTH-DELIVERED SERVICES

Licensure Requirements

(when provider & patient/client are in different states)

Scope of Practice Guidelines

(what services can, and cannot, be administered or billed if provided via telehealth)

CRITERIA FOR REIMBURSEMENT / PAYMENT FOR TELEHEALTH-DELIVERED SERVICES

#1 LICENSURE

Providers utilizing telemedicine or telehealth must be licensed in WA State* to bill for telemedicine or telehealth services provided to a patient located within WA State at the time the service is provided
(**Does not apply to providers in a Direct IHS Clinic, Tribal Clinic, or Tribal FQHC – these providers may be licensed in any state per Federal law)*

When the provider and the patient are in different states…

If a patient is traveling out of state, you must abide by the **laws** and **licensure requirements** of the state they are in at the time of service. (e.g. ensure that the telehealth modality you intend to use is permitted in that state)

CRITERIA FOR REIMBURSEMENT / PAYMENT FOR TELEHEALTH-DELIVERED SERVICES

#2 SCOPE OF PRACTICE

The service provided via telemedicine or telehealth must be consistent with the provider’s scope of professional license or certification.

This is an ethical as well as financial boundary: Providers won’t be paid for any service via telehealth that they aren’t paid to provide in person

CRITERIA FOR REIMBURSEMENT / PAYMENT FOR TELEHEALTH-DELIVERED SERVICES

During the COVID-19 Public Health Emergency, providers can bill for most modalities in the Service Encounter Reporting Instructions (SERI) guide when those services are provided via telehealth

However, there are some exceptions…

CRITERIA FOR REIMBURSEMENT / PAYMENT FOR TELEHEALTH-DELIVERED SERVICES

The following facility based or per diem services cannot be reported or billed as a telehealth per diem claim:

- Free standing evaluation and treatment services
- Day Support
- Mental health or SUD residential services
- Stabilization services in crisis triage or stabilization
- Mental health clubhouse
- Withdrawal management/ secure detox

In some settings (i.e. residential), professional services such as individual treatment or group therapy may be provided via telehealth. Residential level of care must be maintained and the patient must remain physically at the facility, or at a DOH licensed equivalent location such as a quarantine and isolation site. The residential service would still be reported using the per diem code and the clinical record would document how the professional services were rendered.

NOTE: Always document how the services were rendered in the health care record

ALLOWABLE MODES OF TECHOLOGY

For Providing Behavioral Health Evaluation, Assessment, & Treatment Services

Before COVID-19 Public Health Emergency (PHE)

- Telemedicine (real-time, interactive HIPAA-compliant audio-video telecommunication)
- Telephone calls (in specific ways)
- Store-and-forward (tele-dermatology only)

NEVER ALLOWED: Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and should not be used in the provision of telehealth by covered health care providers.

During COVID-19 Public Health Emergency

- Telemedicine (real-time, interactive HIPAA-compliant audio-video telecommunication)
- Telephone calls (**fewer restrictions**)
- Store and forward
- **E-consults** (asynchronous provider-to-provider consultation)
- **Non-HIPAA-compliant telecommunication** (e.g. FaceTime and Skype)
- **Online digital exchange through patient portals**
- **Texting and email** (for virtual check-ins ONLY, using G2012 code)

COMMON TELEHEALTH MODIFIERS

For Documenting Managed Care Encounters (SERI)

For services meeting definition of TELEMEDICINE (real-time, HIPAA compliant audio-video)

- **Place of Service** (**POS**) code: “02”
- **Modifiers**:
  - Use “GT” for telemedicine services billed to managed care: MCOs, BHSO, ASO
  - Use “GT” if you are a distant site practitioner billing for telemedicine under the Critical Access Hospital optional payment method
  - Use “95” if you should receive the non-facility rate

Source: Physician-Related Services/Health Care Professional Services billing guide (wa.gov)

COMMON TELEHEALTH MODIFIERS

For Documenting Managed Care Encounters (SERI)

For services using currently reimbursable TELEHEALTH modalities during PHE:

- **Place of Service (POS)**: Use location-specific code according to location of patient, not provider
  - Home = POS "12"
  - Skilled nursing facility = POS "31"
  - Assisted living facility = POS "13"

  A few examples, not comprehensive list

- **Modifiers:**
  - "CR" (indicates one of the temporary, PHE-allowed telehealth delivery modalities) for **medical services** such as Office Based Opioid Treatment (OBOT)
  - Modifiers for non-medical behavioral health services (e.g. Opioid Treatment Programs at Behavioral Health Agencies) depend on type of payer being billed, and can be found in the corresponding parts of the BH Billing During COVID FAQ

BILLING AS AN ORIGINATING SITE

Definition of Originating Site: The Originating Site is the physical location of the client at the time the telehealth service is provided (e.g. a client has an appointment with a specialist over telehealth from their primary care provider's office). If the originating site is a qualified site, an originating site facility fee may be paid. Qualified sites include:

- Hospital outpatient
- Critical access hospitals
- Federally Qualified Health Centers (FQHC)
- Rural Health Clinics (RHC)
- Physician' or other health professional offices

(Hospital inpatient, skilled nursing facility, home, or other location determined by patient are NOT eligible to bill originating site fees)

NOTE: "Home" is never a billable originating site because the patient is not eligible to receive an originating site fee.

If the provider is in the same location as the client, an originating site fee will not be paid.

Further policy for originating site reimbursement is found in the physician related services billing guide on pages 86-87.

Originating site fees do not apply to Store-and Forward-services between provider and patient.

BILLING AS A DISTANT SITE

Distant Site (based on PROVIDER location): A "distant site" is the physical location of the health care professional providing the health care service to an eligible agency client through telemedicine.

→ Use Place of service (POS) "02" to indicate that a billed service was furnished as a telemedicine service from a distant site.

→ Non-facility providers must add modifier "95" to the claim to receive the non-facility payment

Facility e.g., hospitals, hospital-owned outpatient clinics, skilled nursing facilities

Non-Facility e.g., independent outpatient clinics, private practice offices

AFTER THE PUBLIC HEALTH EMERGENCY (COVID-19)

If there are no policy-level or legislative changes between now (Feb 2021) and the end of the Public Health Emergency (date unknown)…

…HCA will return to the billing policies that were in place prior to COVID-19. (no coverage of telehealth services that do not fit the definition of telemedicine)

Outside of the PHE, HCA does not cover the following services as telemedicine:

- Email, audio only telephone, and facsimile transmissions
- Remote patient monitoring

AFTER THE PUBLIC HEALTH EMERGENCY (COVID-19)

Potential avenues for long-term telehealth billing policy changes:

- **Changes to federal budget providing Medicaid funding to states for tele-behavioral health services**
  - Go to Congress.gov and search for "telehealth" to see list of bills (as of Jan 6, 2021 there were 116 search results)

- **Changes to WA state law mandating coverage of specific telehealth services, and associated rates of payment**
  - 2021 legislative session from January 11 – April 25
  - Go to leg.wa.gov to search for telehealth bills

AFTER THE PUBLIC HEALTH EMERGENCY (COVID-19)

Potential avenues for long-term telehealth billing policy changes:

- **Changes to federal budget providing Medicaid funding to states for tele-behavioral health services**
  - Go to Congress.gov and search for "telehealth" to see list of bills (as of Jan 6, 2021 there were 116 search results)
- **Changes to WA state law mandating coverage of specific telehealth services, and associated rates of payment**
  - 2021 legislative session from January 11 – April 25
  - Go to leg.wa.gov to search for telehealth bills

ISSUES TO WATCH:

- Audio-only coverage & payment rates
- Remote patient monitoring

ADDITIONAL RESOURCES FOR TELE-BEHAVIORAL HEALTH BILLING

Billing During COVID-19 PHE

- HCA Behavioral Health Billing Policy: Apple Health (Medicaid) behavioral health policy and billing during the COVID-19 pandemic (FAQ), *updated December 1, 2020*
- Opioid Treatment Programs: COVID-19 and Opioid Treatment Programs FAQ, *updated March 4, 2020*

Additional Resources

- CCHP State Telehealth Laws & Reimbursement Policy (Fall 2020)
- SAMHSA COVID-19 page
- SAMHSA: COVID-19 Public Health Emergency Response and 42 CFR Part 2 Guidance
- SAMHSA: Opioid Treatment Program (OTP) Guidance, *updated 3/19/2020*
- DEA: Use of Telemedicine While Providing MAT, *updated May 1, 2020*
- HCA COVID-19 and prescribers of buprenorphine containing products in office based opioid treatment settings FAQ

Behavioral Health Institute (BHI)
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BEHAVIORAL HEALTH TELEHEALTH RESOURCE

For more information including upcoming training
& additional resources:

Visit us online:
https://bhi-telehealthresource.uwmedicine.org/

Email us:
melmckee@uw.edu

Slides & resources will be posted after the session
https://bhi-telehealthresource.uwmedicine.org/

After today's session:

- Required Registration at Pre-Registration (iths.org)

- Post-webinar email:
  - Evaluation - required for each session to obtain a Certificate of Completion.
  - CME information – nominal cost.
  - Certificate of Completion - no cost.
    - May be able to use Certificate of Completion to meet CE requirements.

April 8

TELEBEHAVIORAL HEALTH 101

- 6-module Online Self-Study* https://NRTRC.catalog.instructure.com/programs/telebehavioral-health-101-series

  Or….
- 6-session Interactive Webinar Register at: https://uw-phi.zoom.us/webinar/register/WN_64sfo7hrT-6TOibLXQUxIQ

- Introduction to TeleBehavioral Health and Policy Overview* (webinar 11am-12pm on 1/8/21)
- Getting started: Facts & Myths, and Security & Privacy (webinar 11am-12pm on 1/22/21)
- Digital Health Do's & Don't's, Workflows, and Safety planning (webinar 11am-12pm on 1/29/21)
- Billing and Reimbursement for TeleBehavioral Health (webinar 11am-12pm on 2/5/21)
- Clinical Engagement over Telehealth (webinar 11am-12pm on 2/12/21)
- Clinical Supervision in Telehealth (webinar 11am-12pm on 2/26/21)

***Session 1 will meet the requirements for telehealth training as established by Washington SB6061, effective January 2021. A certificate will be issued for each module completed.**

Please see next slide for CME information….

TELEBEHAVIORAL HEALTH 101

CME Information

- **6-module Online Self-Study***

https://NRTRC.catalog.instructure.com/programs/telebehavioral-health-101-series

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this enduring material for a maximum 1 *AMA PRA Category 1 Credit™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Learners have the opportunity to complete up to 6 modules, with each module accredited for 1 *AMA PRA Category 1 Credit™.*

- **6-session Interactive Webinar**

Register at: https://uw-phi.zoom.us/webinar/register/WN_64sfo7hrT-6TOibLXQUxIQ

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of ***6*** *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.0 credits)

*******Learners may obtain CME credits from the online self-study module OR the webinar series, but not both.*******

BEHAVIORAL HEALTH INSTITUTE

HARBORVIEW MEDICAL CENTER

UW Medicine King County

TELEBEHAVIORAL HEALTH 201 SERIES

Monthly series: 3rd Friday of each month, 11am-12pm PST:

- **10/23/20 – TELEHEALTH POLICY – THE CHANGING FEDERAL AND STATE LANDSCAPE**
- **11/20/20 – PREPARING PATIENTS & TECHNOLOGY for TELEHEALTH**
- 12/18/20 – DOING GROUPS over TELEHEALTH
- 01/15/21 – MOBILE HEALTH (mHEALTH) FOR SERIOUS MENTAL ILLNESS
- 02/19/21 – PROVIDER SELF-CARE & WELLNESS in the ERA of TELEHEALTH and COVID
- 03/19/21 – BEHAVIORAL HEALTH APPS
- 04/16/21 – CHILDREN and TELEBEHAVIORAL HEALTH
- 05/21/21 – APPLYING TELEHEALTH to SUD TREATMENT in COMMUNITY-BASED SETTINGS
- 06/18/21 – (tentative) CULTURAL COMPETENCE & HUMILITY in TELEBEHAVIORAL HEALTH
- 07/16/21 – APPLYING TELEHEALTH to MEASUREMENT-BASED CARE
- 08/20/21 – SUICIDE RISK ASSESSMENT over TELEHEALTH
- 09/17/21 – COUPLES & FAMILY THERAPY over TELEHEALTH

A CERTIFICATE OF COMPLETION WILL BE ISSUED FOR EACH SESSION ATTENDED

Register at: https://uw-phi.zoom.us/webinar/register/WN_6GBzJWGXRE6yNM9N_fRIjA

CME Accreditation

The University of Washington School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of Washington School of Medicine designates this live activity for a maximum of ***12** AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity. (Each session is 1.0 credits)

TELEBEHAVIORAL HEALTH 101 and 201 SERIES

Continuing Education for Social Workers

This series has been approved for CEUs by the Washington Chapter, National Association of Social Workers (NASW) for Licensed Social Workers, Licensed Marriage & Family Therapists and Licensed Mental Health Counselors. Our Provider number is #1975-433. (Each session is 1 credit)