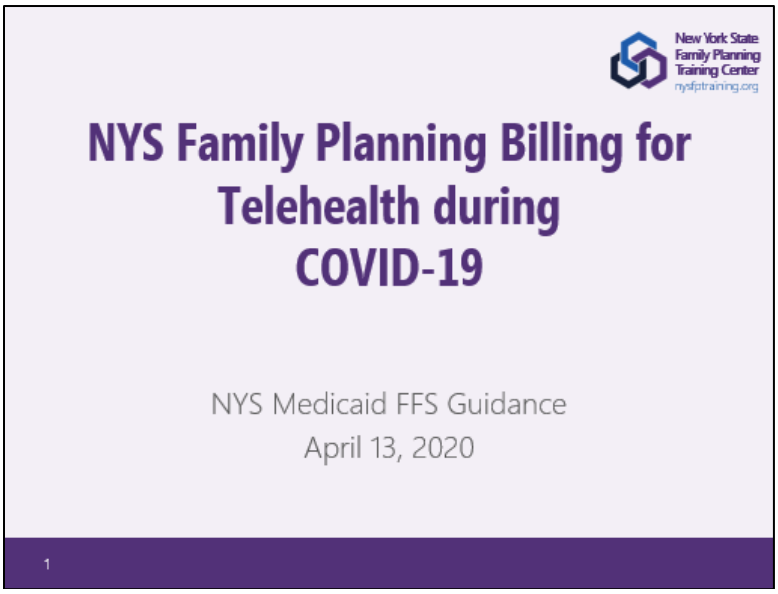
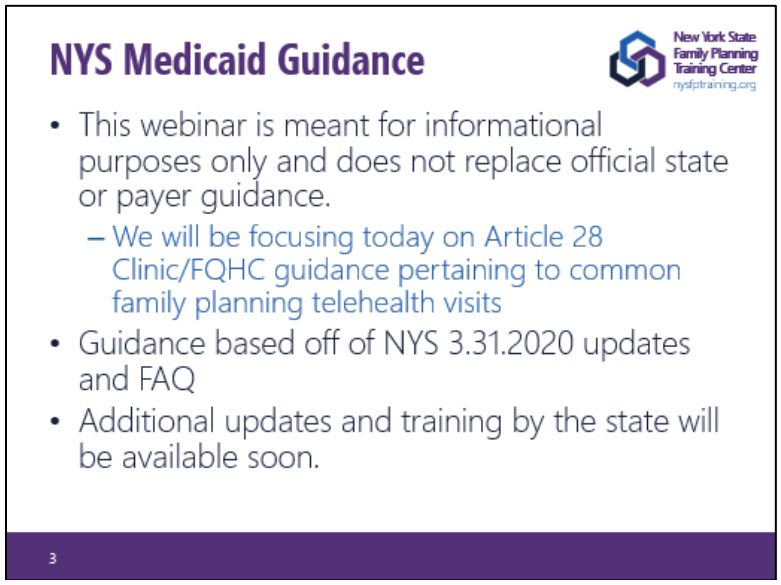
Transcript for NYS Family Planning Billing for Telehealth during COVID-19

April 13, 2020

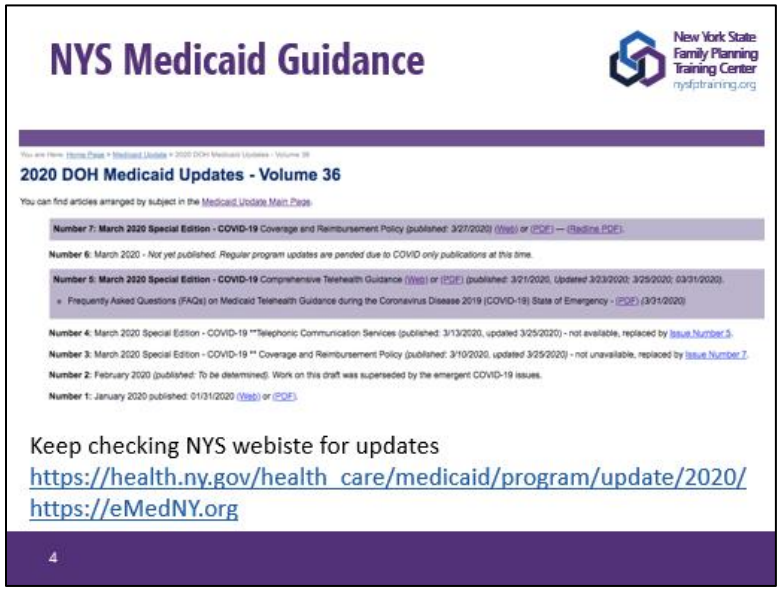


Katie Quimby: Good afternoon everyone, and welcome. My name is Katie Quimby, and on behalf of the New York State Family Planning Training Center, I'd like to welcome you to today's webinar about family planning billing for telehealth during COVID-19. Before we begin, I have a few very brief announcements. First, everyone on the webinar today is muted to reduce background noise. If you pre registered for the webinar, you should have already received a copy of the slides by email. We are also recording today's webinar, and the recording will be posted to our website, nysfptraining.org, within the next few days, along with the slides. Please feel free to chat your questions in at any time. You can find the chat pod by hovering over the webinar screen.

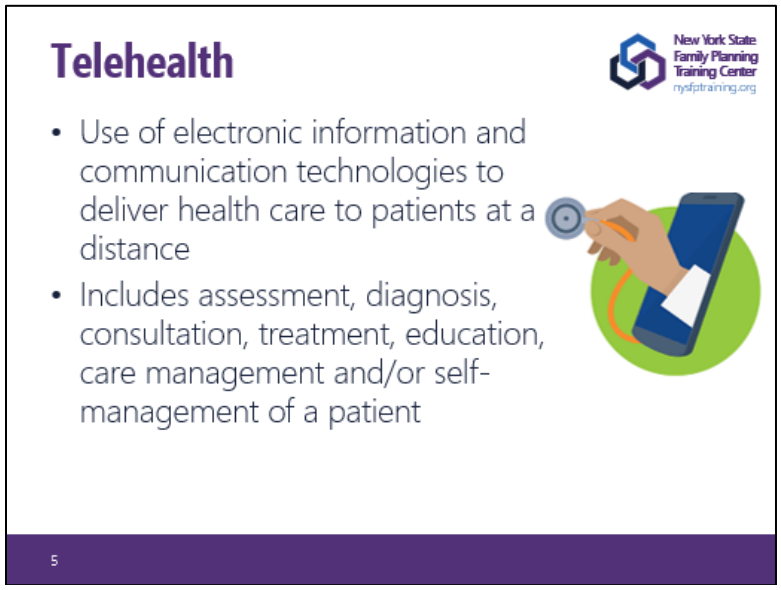
Katie Quimby: I'd now like to introduce our speakers for today's webinar. First, Ann Finn is a reproductive and sexual health billing expert and national trainer, and she frequently speaks on issues related to coding, billing, reimbursement, and improving the overall revenue cycle. We are also going to be joined by Rae Ann Augliera and Eileen Shields from the New York State Department of Health. With that, let's get started.



Ann Finn: Hello everyone. Today, we're going to be focusing on Article 28: clinic and FQHC guidance pertaining to common family planning telehealth visits, based on the available guidance on NYS Medicaid webpage. It was last updated on March 31st in recent DOH clarifications. As I was putting together these slides, there were a few areas that were unclear in the guidance and FAQ. The state was able to clarify some of my questions, but also said that they would be putting out additional clarifying guidance shortly, that will include some changes to the March 31st updates, so just beware. Some of these are clarifications I incorporated into today's webinar, and some I've left is kind of to be determined because I want to wait for the state's guidance to come out and see what they have to say. So, again, look for these updates. They said that they will be coming shortly.



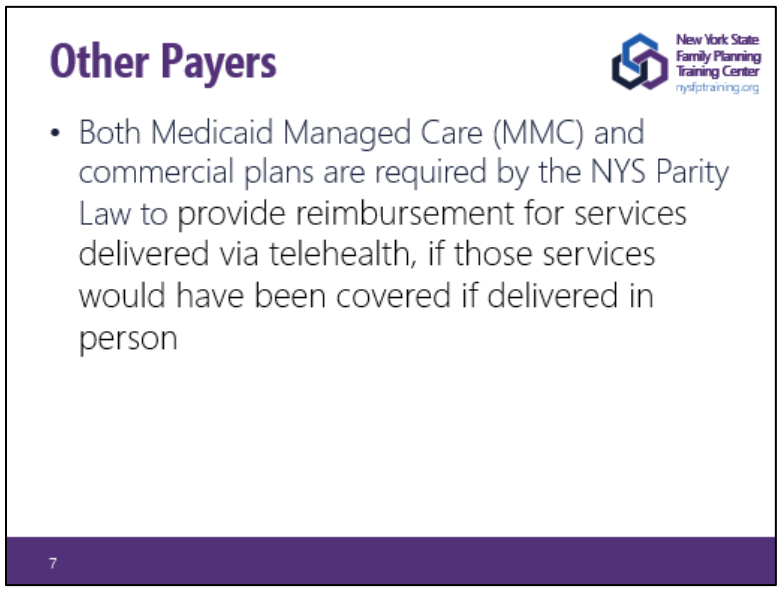
Ann Finn: This is the New York State website, where the updates are posted every month. And this is where you can find the information for the COVID updates, and it's under the March. And if you go here, you can see some of these have been not available any longer, but the ones in purple are what are available. And as you can see, that number five has been updated a number of times, and will be updated again shortly in the FAQ. You can also go out to emedny.org. And on the homepage, on the right hand side, you can sign up on the LISTSERV button, and you can sign up to automatically get an email for the Medicaid updates each month.



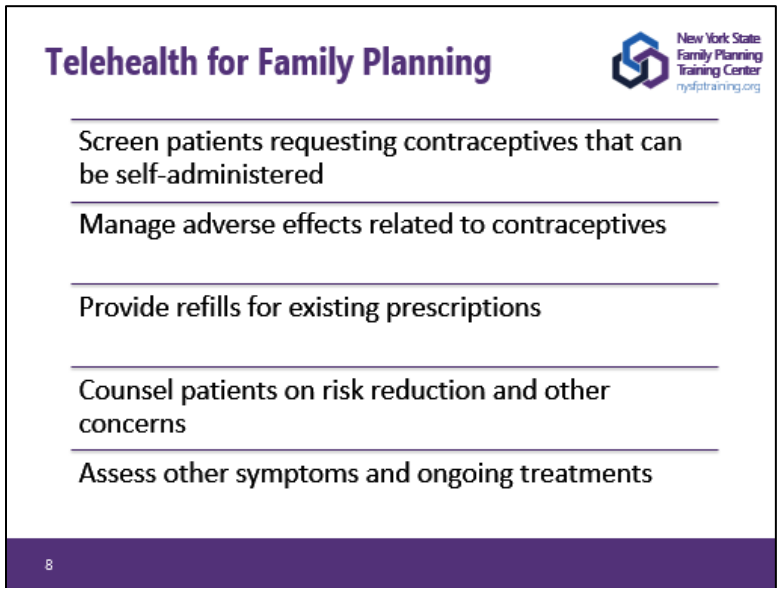
Ann Finn: So, let's start with just defining what telehealth is and a few key terms. Telehealth is defined as the use of electronic information and communication technologies to deliver healthcare to patients at a distance. New York State Medicaid covered services provided via telehealth include assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a Medicaid patient. The use of telehealth services can help ensure access to essential contraceptive services, while at the same time limiting exposure to COVID-19 for both health care workers and for the patients. For today's webinar, we're going to focus on Article 28 billing for family planning services, focusing on the patient being in the home setting and not going into the clinic, because that's what most of us are dealing with at this point. Article 31 on mental health has issued separate guidance and that should be reviewed and is not included in today's webinar.

Ann Finn: In New York State, these services must be delivered by providers that are acting within their scope of service, and it should be a covered service as well. So that hasn't changed. It's still the same providers. There has been some relaxing of what the providers can do, but it's within their scope of practice. And it's also important to review the guidance and requirements put forth by your specific managed care and commercial plans to ensure that you accurately bill for telehealth during the emergency. Covered services

and billing guidance may vary for the different payers. So having your billing team trained on how to bill and what payments to expect will help to ensure you're paid accurately and you don't miss out on unexpected revenue. That's one of the big things that I find, is knowing what payment should be expected so that you can kind of flag the ones, even if they are paid, if they're not paid appropriately, then we can flag those and get those corrected and resubmitted back into Medicaid.



Ann Finn: The New York state telehealth Parity Law requires commercial insurers and the Medicaid program to provide reimbursement for services delivered via telehealth if those services would have been covered if delivered in person during COVID-19. Medicaid managed care plans are required to cover at a minimum services that are covered by Medicaid fee-for-service, and also included in the managed care package when determined medically necessary, and they should be following the fee-for-service telehealth billing policy included in the state's guidance as well. And you should always direct questions for different payers, including managed care, to the plans specifically because they all might have some different nuances going on and we want to make sure that the claims getting submitted are submitted accurately so they get paid the first time.

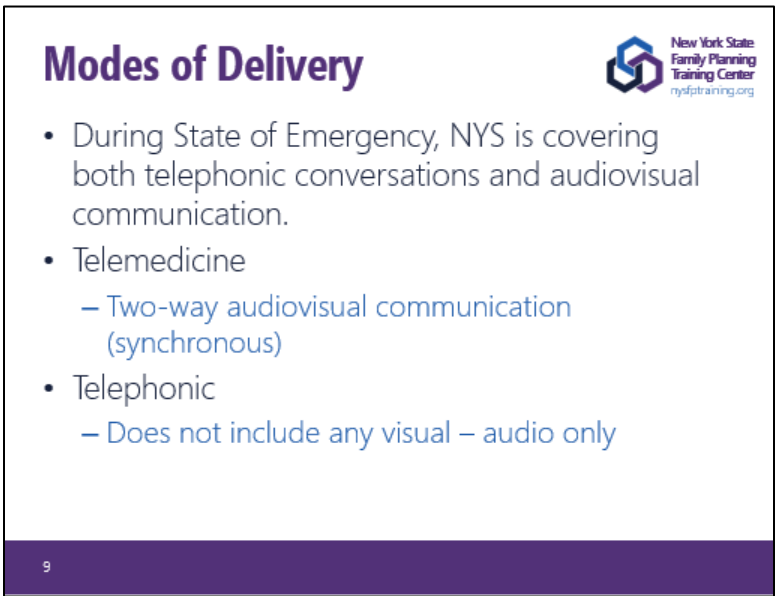


Ann Finn: Okay. Let's think about telehealth for family planning and what applies. During a state of emergency, many of our patients will continue to need contraception and have other family planning needs met. The state expanded definitions of billing telehealth to include all services and diagnosis, not only the COVID-19 related care, to help patients at home and reduce the risk of exposure for everyone.

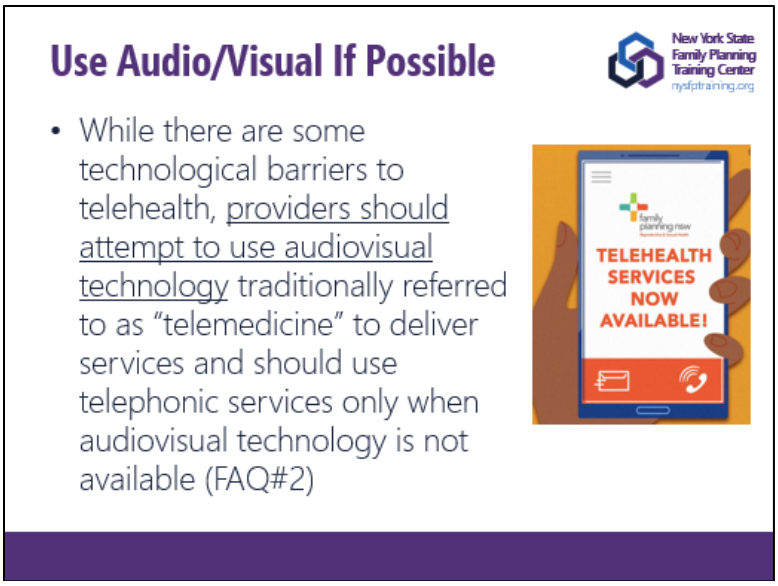
Some common scenarios: a family planning visits that could take place as telehealth might include screening patient, requesting contraceptives that can be self-administered. Patients may safely be screened and offered prescriptions if they do not have any risks for using that method.

You can manage adverse effects related to contraceptives by telehealth when possible. You can provide refills for existing prescriptions, and we encourage patients to fill prescription contraceptives by mail or drive-through pharmacies when available.

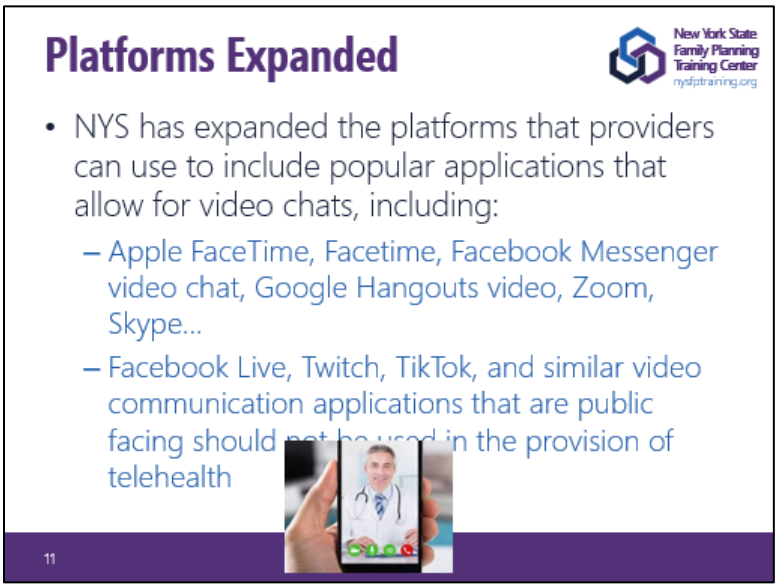
The less that they're going into the pharmacy and in contact with people, the better. Counsel patients on risk reduction, safe sex and other concerns. And then also, are you going to be assessing other symptoms and ongoing treatments? So all things that we're familiar with doing in the clinic but can now be done as telehealth.



Ann Finn: So during the state of emergency, New York is covering both telephone conversations and audio-visual or telemedicine. You hear the term telemedicine, that's audio-visual or telephonic. The dates of service, on or after March 1st. So both telephonic and audio-visual are covered. Patients should be treated through telehealth whenever possible to avoid the risk of exposure by coming into the clinic and being in contact with others. The decision to provide or to not provide services to telemedicine or telephonically is a clinical decision made by the provider and documented in the record.



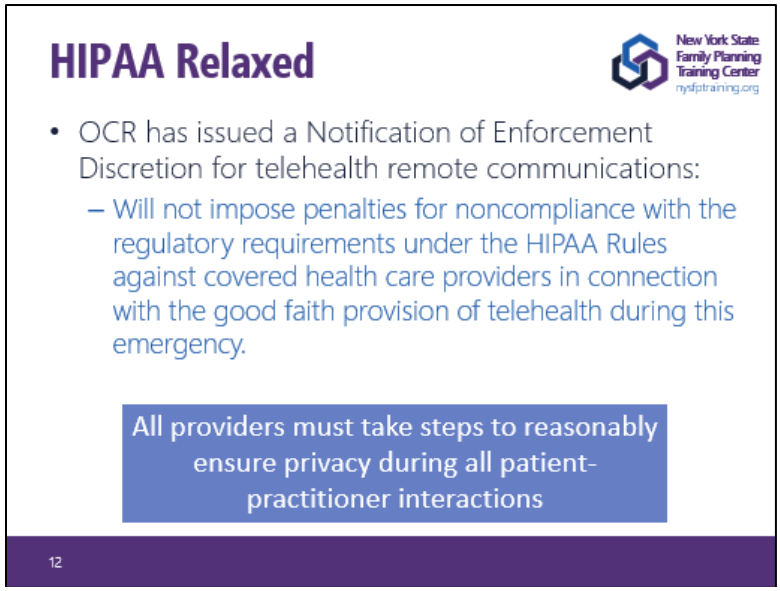
Ann Finn: Providers should first attempt to use audio-visual technology to deliver services and to use telephonic services only when audio-visual technology is not available. So, if you have the opportunity to use your telemedicine system that are within your EHR system that would be your first option.



Ann Finn: And then kind of going down the line to some of the smartphone applications and then to the telephone. In an effort to reduce the need for travel to clinics and other healthcare facilities, new York state has expanded the platforms that providers can use to include popular applications that include video chats. These would include Apple FaceTime, FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom and Skype, just to name a few of them that are popular, along with your existing telehealth system.

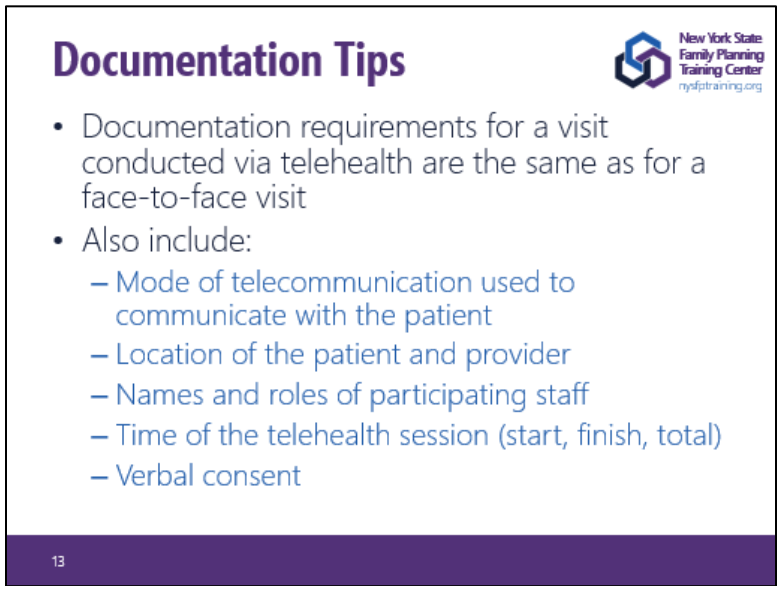
However, you shouldn't use those public facing platforms, things like Facebook Live and TikTok, TikTok's really popular, twitch and similar video communication applications like that. You should always enable all encryption and privacy modes when using these applications and take steps to reasonably ensure privacy during all patient practitioner interactions. It's important to talk to the patient about reduced privacy connections and risks.

It's okay to use these platforms, but again, we want to really try to use as much security as we can, of course, to protect that confidential information. So what about HIPAA during this COVID emergency in regards to telehealth? The Office of Civil Rights, or OCR, at health and Human services is responsible for enforcing certain regulations issued under HIPAA to protect the privacy and security of protected health information.



Ann Finn: During the COVID-19 emergency, some of the technologies that are being allowed to communicate with patients may not fully comply with the requirements of the HIPAA rules. So, to accommodate this, the OCR has issued a notification of enforcement discretion for telehealth remote communication. You'll see this on the CMS website and New York Guidance also talks about it.

And they will not impose penalties for noncompliance with the regulatory requirements under the HIPAA rules and healthcare providers in connection with good faith provision telehealth during the emergency. So, because they're saying it is okay to use these platforms, they're also saying that we're going to allow a little bit of HIPAA relaxing of the rules. So this applies to telehealth provided for any reason regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. So the same protection falls under family planning and for the services that you are providing.



Ann Finn: Okay. How about documentation? People have asked kind of, how do we document these visits? And of course, documentation is critical. The documentation requirements for a visit conducted via telehealth are the same as a face-to-face visit.

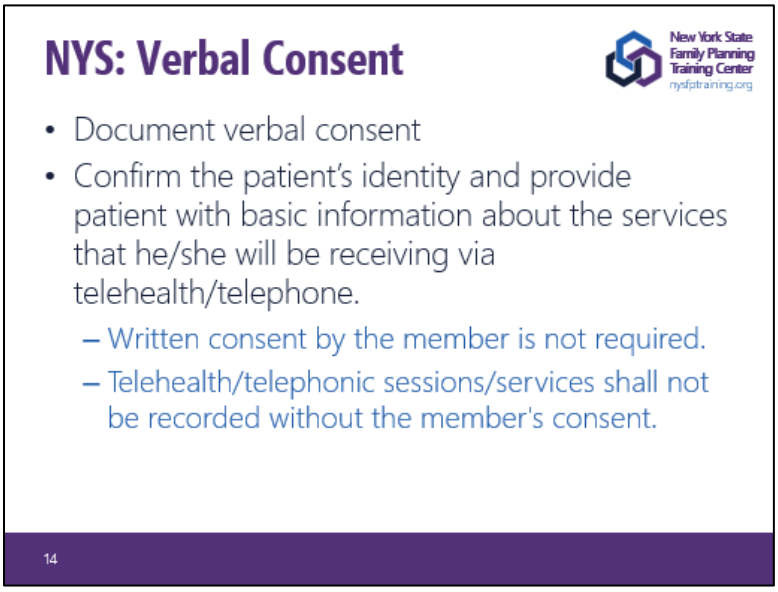
You need to make sure that you have in your chart note all of the services that are happening. You want to manage or document all diagnoses that you are managing during the visit. You want to document the rationale for ordering diagnostic tests and procedure if necessary.

If someone's got to drop off a sample or come in and have testing done, we want to make sure that that's documented. We want to include notes on all the counseling that's being provided and we ought to really clearly describe the management of the patient. Are you prescribing a refill of a contraceptive? Maybe pills or a patch and prescribing it or telling them about it over the counter and medication. So things that are happening within the visit, just like if you were face-to-face, we would document those the same.

But for telehealth, what we also want to document is the mode of telecommunication that's used with the patient. So, are you using your tele medicine system that's internal to your system? Are you using FaceTime? Are you using the telephone?

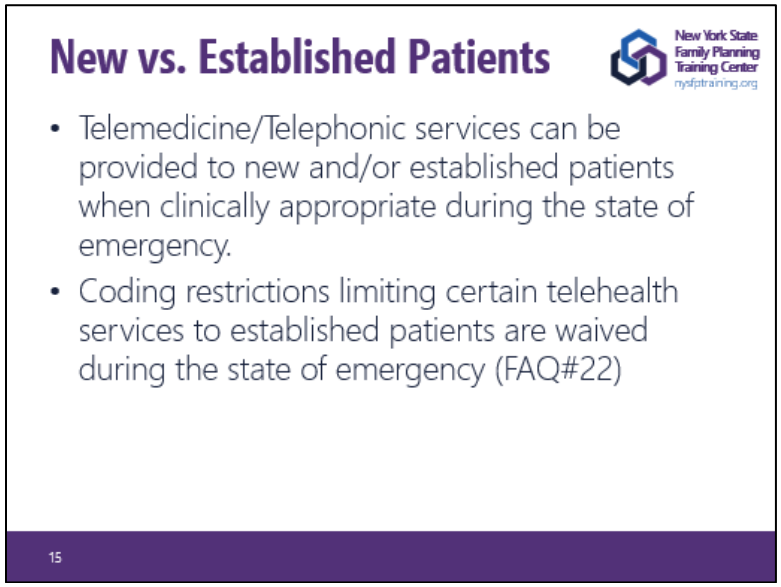
Make sure that that's documented in the record. The location of both the patient and the provider. Are you both at home? Is a provider at the clinic and the patient's at home? Make sure that the note clearly states this. The names and roles of this other staff that are involved in the service, if that's applicable or if it's just you. And most importantly is the total time spent during the telehealth service. As I mentioned, it's really critical as many of these services are based off of time and the payments are based off of time. So we really need to capture that time kind of clearly.

I've seen a few different templates where they have kind of right up at the top, kind of up by the HPI. They've kind of got an area to add that information in so that the providers are not forgetting to document it, and that would really make it easy for everybody, is to have some fields added into the EHR and the chart note.

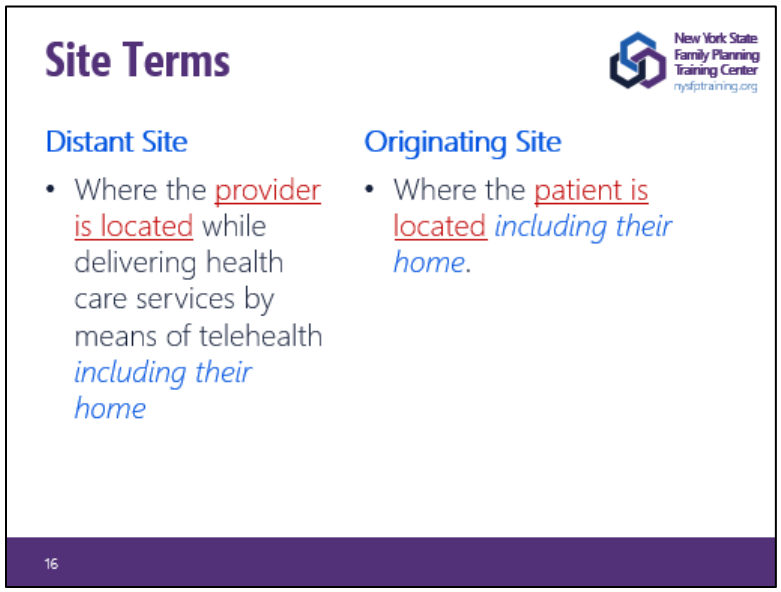


Ann Finn: So we need to document verbal consent in the patient's record. New York Guidance states that the practitioners shall confirm the patient's identity and provide the patient with basic information about the services that he or she will be receiving via telemedicine or telephone. Written consent by the patient is not required at this time. And remember, telemedicine, telephonic sessions and services should not be recorded

without the patient's consent. Telehealth is normally limited to establish patients, but during the state of emergency, both telemedicine and telephonic services can be provided to new and established patients when clinically appropriate.

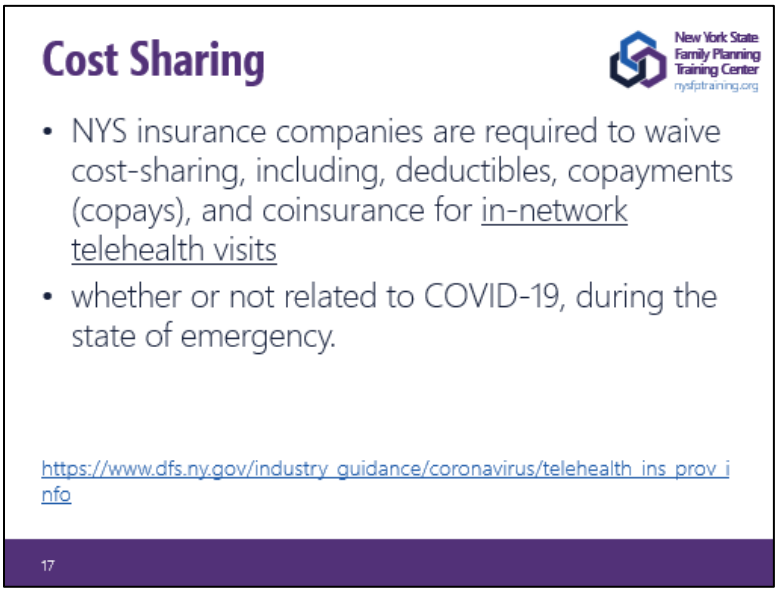


Ann Finn: Coding restrictions limiting certain telehealth services to establish patients are waived. Rate codes used to bill for telephonic care will be all inclusive and not dependent on a CPT code for the Article 28 billers as well. And CMS has also stated, that during the emergency, to the extent that the waiver requires. That during the emergency to the extent that the waiver requires that patients have a prior established relationship with the practitioner, HHS will not conduct audits during this public health emergency. Again, we want to provide these services to both new and established patients, and you don't need to worry about having that established patient relationship for the telehealth service.

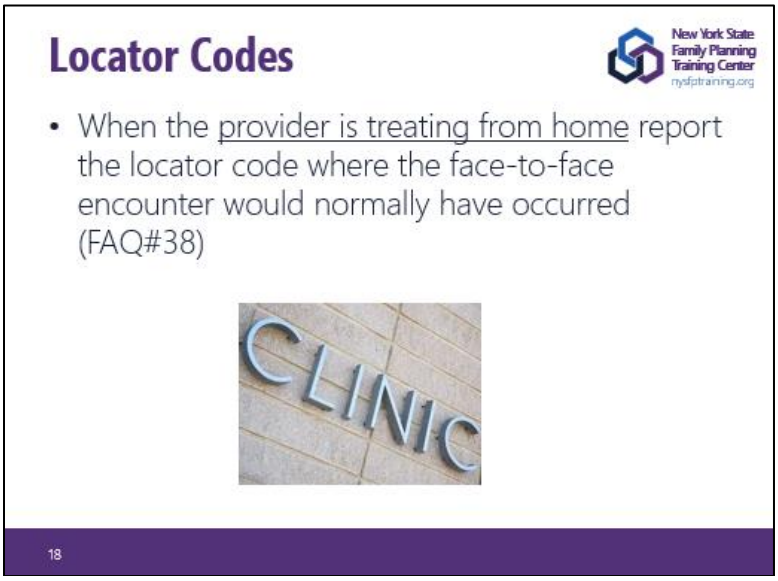


Ann Finn: A couple of terms that we always hear when we're talking about telehealth, so I want to make sure that everybody's clear on them is distance site. That is where the provider is located. When you're looking at the state's guidance or a different payers' guidance, and it talks about the distance site, that is where the provider is located. That can include anywhere right now during this emergency, including your home. Your originating site

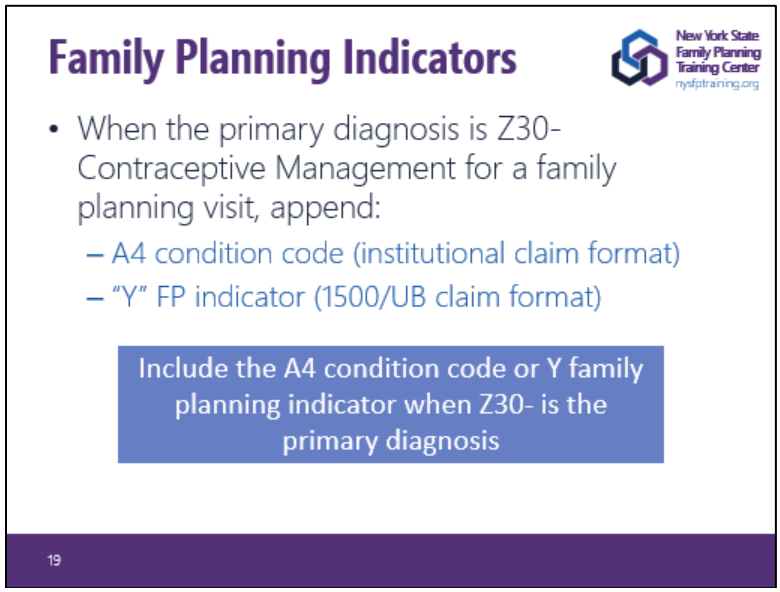
is where the patient is located. Again, it can be anywhere right now during the emergency, including their home. Sometimes there's guidance, and we're sticking with, I mentioned today that the patient being at home, in some situations the patient can be at the clinic and then receiving telemedicine services from another provider. There is guidance if you go through state's guidance on that. But we're focusing on the common scenario of what's happening with family planning providers and the questions that are being asked.



Ann Finn: How about cost sharing? New York State Department of Financial Services, or DFS, has adopted a new emergency regulation that requires New York state insurance companies to waive cost sharing, including deductibles, copayments, and co-insurance for in-network telehealth visits, whether or not they're related to COVID-19 during the state of emergency. All the services under telehealth, the cost sharing and deductibles, are waived right now.

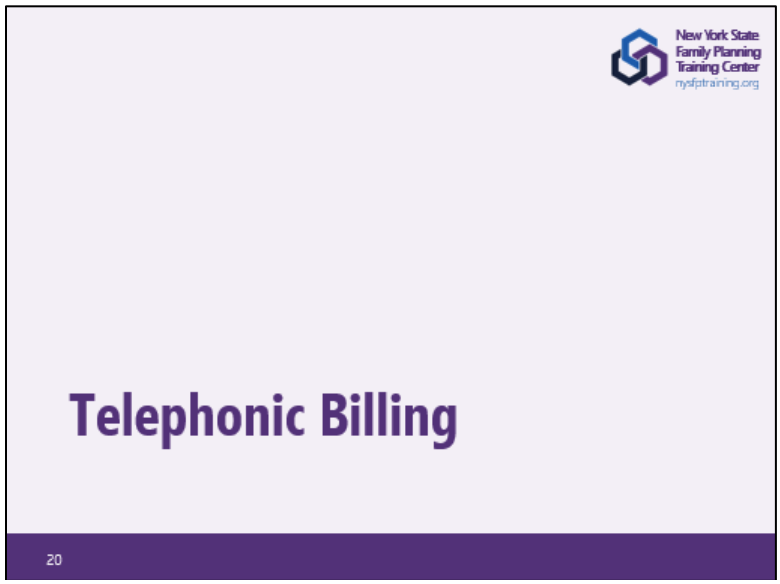


Ann Finn: When we're billing a claim, we always include a locator code for your facility, and that's usually a code with your zip, you want to still during this time, regardless of where your provider is located, we want to use the locator code that is for where the clinic is. Where would the provider normally be when the face to face encounter is happening? If you're home, you're still going to use the locator code at the clinic.



Ann Finn: Family planning indicators, and I see this sometimes missed on family planning claims, so it's really important that on all claims whether the telehealth or regular face to face visits, that when the visit is a family planning visit and the Z30 ICD 10 diagnosis code, Z30 contraceptive management is the primary diagnosis. Then we need to append an A4 condition code up in the header of a claim for the institutional claim format or if you're using the UB claim format or a professional claim, then it's a Y family planning indicator. That goes on though the line of the CPT codes. There's a box for the family planning indicator.

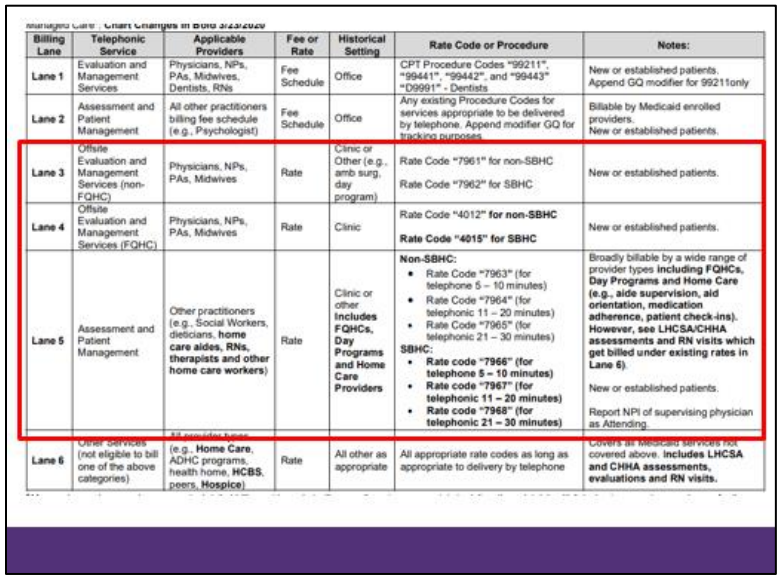
Either claim format that you're using and both and in face to face, if you're doing a LARC insertion and you have an ordered ambulatory claim or your APG claim or your PPS claim for the visit you would use in the family planning indicator. We want to include these indicators on the telephonic and the telemedicine claims as well. In this family planning and care, and it's important to use. The state requires that they go on the claims and say that no, if you don't use them under audit, there's a risk of take-back of payments, and it allows the state to get the 90% federal match for the family planning services.



Ann Finn: Let's talk a little bit specifically about telephonic billing for the telephone calls. This is new for

telehealth, and this is just during the emergency. Not all states are allowing this, but New York State is, so let's talk about some of the specifics. For billing, both telephonic or audio/visual or telemedicine differs, and it's important to set up your EHRs and billing systems to accurately bill to these services. There's some nuances for depending on the format.

Ann Finn: Billing staff will need to be trained on these new codes, and what CPT codes should be billed. Services will be paid for by specific rate codes and an all inclusive payments for the clinics and FQHCs. Telephonic visits are described in the New York state guidance. If everybody's looked at it, you'll see it on page three, there's a big chart we're going to look at and that's use lanes. That's what it kind of describes what type of provider you are and then you look to the appropriate lane for how you're going to be billing.



Billing Lane	Telephonic Service	Applicable Providers	Fee or Rate	Historical Setting	Rate Code or Procedure	Notes:
Lane 1	Evaluation and Management Services	Physicians, NPs, PAs, Midwives, Dentists, RNs	Fee Schedule	Office	CPT Procedure Codes "99211", "99441", "99442", and "99443" "D9991" - Dentists	New or established patients. Append GQ modifier for 99211only
Lane 2	Assessment and Patient Management	All other practitioners billing fee schedule (e.g., Psychologist)	Fee Schedule	Office	Any existing Procedure Codes for services appropriate to be delivered by telephone. Append modifier GQ for tracking purposes	Billable by Medicaid enrolled providers. New or established patients.
Lane 3	Offsite Evaluation and Management Services (non-FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic or Other (e.g., amb surg, day program)	Rate Code "7961" for non-SBHC Rate Code "7962" for SBHC	New or established patients.
Lane 4	Offsite Evaluation and Management Services (FQHC)	Physicians, NPs, PAs, Midwives	Rate	Clinic	Rate Code "4012" **for non-SBHC** **Rate Code "4015" for SBHC**	New or established patients.
Lane 5	Assessment and Patient Management	Other practitioners (e.g., Social Workers, dieticians, **home care aides, RNs, therapists and other home care workers**)	Rate	Clinic or other **Includes FQHCs, Day Programs and Home Care Providers**	**Non-SBHC:** • Rate Code "7963" (for telephone 5 – 10 minutes) • Rate Code "7964" (for telephonic 11 – 20 minutes) • Rate Code "7965" (for telephonic 21 – 30 minutes) **SBHC:** • **Rate code "7966" (for telephone 5 – 10 minutes)** • **Rate code "7967" (for telephonic 11 – 20 minutes)** • **Rate code "7968" (for telephonic 21 – 30 minutes)**	Broadly billable by a wide range of provider types **including FQHCs, Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins). However, see LHCSA/CHHA assessments and RN visits which get billed under existing rates in Lane 6).** New or established patients. Report NPI of supervising physician as Attending.
Lane 6	Other Services (not eligible to bill one of the above categories)	All provider types (e.g., **Home Care**, ADHC programs, health home, **HCBS**, peers, **Hospice**)	Rate	All other as appropriate	All appropriate rate codes as long as appropriate to delivery by telephone	Covers all Medicaid services not covered above. **Includes LHCSA and CHHA assessments, evaluations and RN visits.**

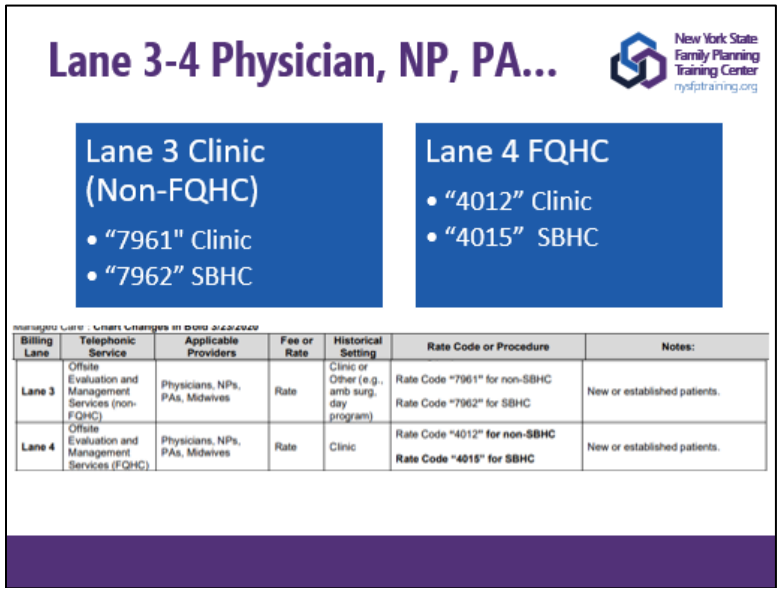
Ann Finn: Let's take a look at that table. I know it's a little bit busy, but here we go. Here's the state's guidance. If we look, there's a lot of information here, but what's important, and again, these are in the Medicaid update in the FAQ, where you can refer to this table. The chart has two basic sections. Lanes one and two are used for fee schedule billers, primarily practitioners in the office based settings and lanes three through six are for all of the billers that primarily bill rates for clinic and other services.

We're going to focus on lanes three to five today. Lane five or article 28 clinics and FQHCs should be using lanes three, four and five. Lanes three and four are for the evaluation management services by the physician, the NP or other qualified healthcare professional that normally bills ENM services. You're going to use lane three if you are an article 28 clinic and lane four if you are an FQHC.

Lane five is for other practitioner types such as social workers, dieticians, RNs, and should be used for any and all patient assessment and management services that are appropriate to be billed telephonically unless otherwise noted for both clinics and FQs. Lane six is reserved for all other services that don't fit into the first five lanes. More guidance is going to be issued on lane six, but they're saying like 90% of the visits should really fall under lanes one through five, so we're not going to worry about lane six today.

All right, this table is very helpful for setting up your billing systems and include a lot of those codes that we're going to need. We want to make sure all our billers have access to this. Let's go back to lanes three and four, and these are for the physician, NP and other qualified healthcare professionals that are billing ENM services. Remember lanes three and five have new rate codes. We'll look at five on the next slide, but these special rate codes are not in your billing systems right now.

We really need to make sure that they're mapped appropriately in your systems and that they're going out to the claim appropriately. You should do some testing, get them loaded and then test that they're going out as indicated with all the different family planning services that you think are going on claims, because sometimes what we think is on the claim is not what happens behind the scenes.



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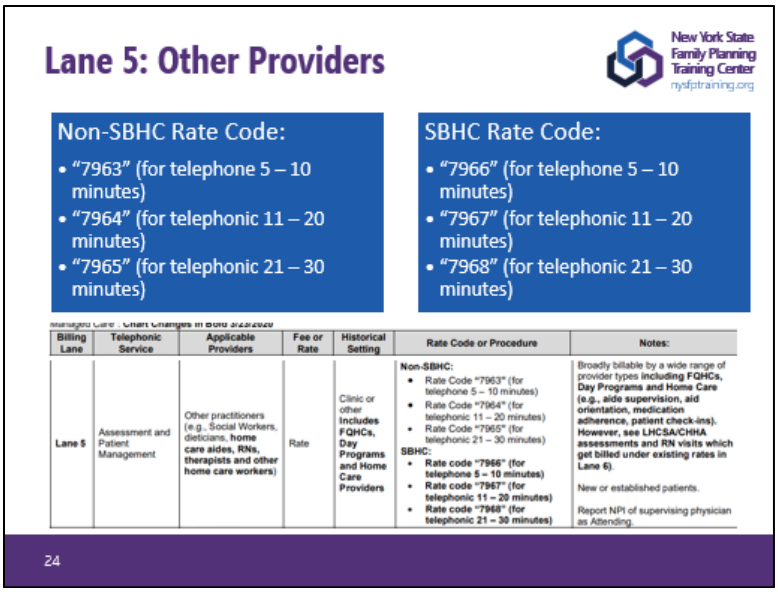
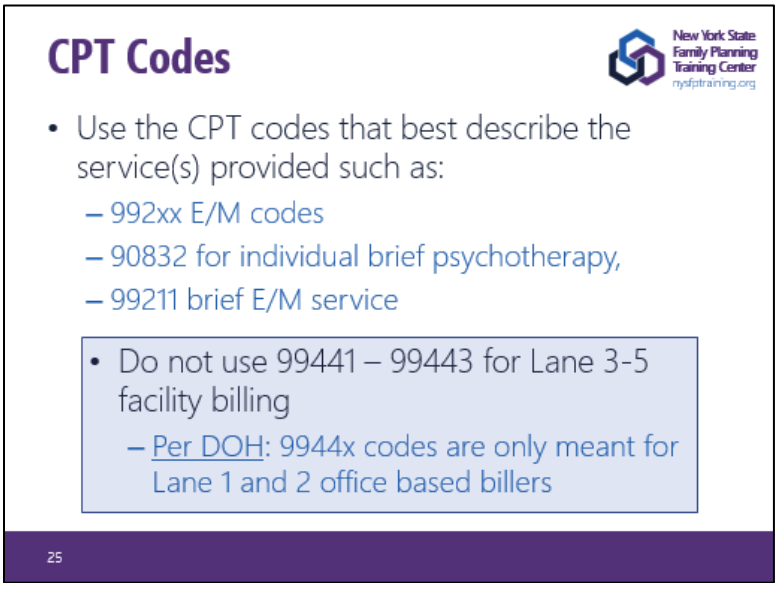
Ann Finn: These payments for lanes three and five again, they are going to be all inclusive and for the facility type end, the Department of Health has told me they're not published yet, so I don't know what those rates are going to be. Lane four is the 4012 is a rate code that's already established for the FQHCs, for the offsite ENM services. These are already in the rate files, and there's 4015 if you're a school based health center. When I looked at the rate file, most of the FQHCs have around a $70 payment for those rate cuts. I assume that that's what's going to be the payment for the FQHCs, but again they haven't published the rates or that guidance yet to confirm the rate.



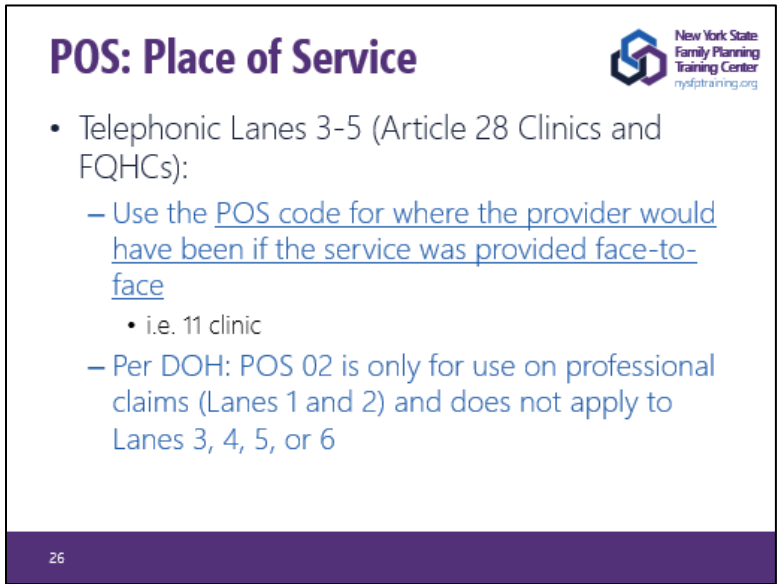
Ann Finn: Let's look at lane five for other providers. Here you can see that there's new rate codes. Again, just like in lane three, so the FQHC is hopefully your 4012 or 4015 is in your system, but check that and then they should be added. For the assessment and patient management telephonic services, you want to stick to this lane, and it would be by these practitioners that we've mentioned. I mentioned social workers, RNs, dieticians, and it's all based on time. You can see there's these three different codes, but the state has told me that you're still supposed to bill the CPT code that best describes the service that is provided.

Then you want to bill time, and then you're going to match the rate code to the time. It's not so much driven by the CPT code, it's driven by the documented time, what rate code that you will pick. You're also going to need to include the NPI. You can see down here at the bottom of the box, the NPI, the supervising physician as the attending on the claim, and that's just for lane five.



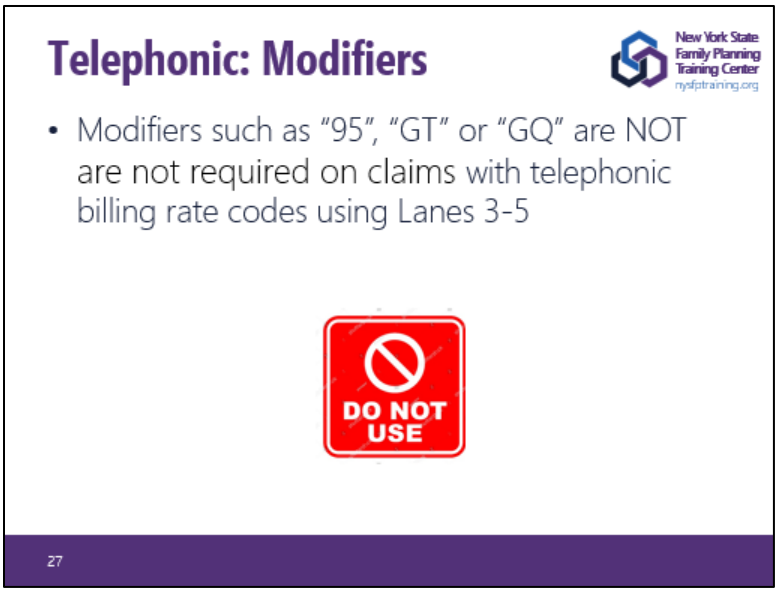
Ann Finn: Like I mentioned for all the services, use the CPT codes that best describe the services provided, such as for lanes three and four. You're going to use ENMs codes and 992 codes for outpatient services. If you're a licensed clinical social worker and you're doing individual psychotherapy, you would bill a code for the service 90832 that you normally do or whatever service that is being provided.

There's been a lot of questions on billing 99441 through 99443. These are the telephone evaluation and management codes, which I would have expected that maybe those would get used. But the Department of Health has been very clear that no, those are really for just those lanes one and two, the office-based billers and not for facility billings. They said lanes three through five you should not be using the 99441 to 443 codes. Then you can look through the updated guidance when it comes out, hopefully this week, to see if anything has changed on that, but that was as a Friday some of the responses that I got back from them.



Ann Finn: Place of service as a code that goes on the claim. This is an area that's been a little bit confusing in some of the guidance, so the place of service code, what they've instructed is to use the place of service code where that provider would have been located if the service had been provided face to face. For example, the clinic, and DOH also clarified that using the POS of O2, which is for telemedicine, is only for professional claims in lanes one and two, and it does not apply to lanes three, four, five and six.

There's some talk about POS 02 in the guidance and in the FAQ. There's a number of contradicting statements in the FAQs about it. This was last Thursday and Friday's follow up from the state. Again, I would review the guidance once it's updated to make sure that they didn't make any additional changes to that. I think they were trying to figure out their way and figure out what conflicts are outstanding as well as all of us. Does that make sense? Use the POS code where provider would have been located if the service was provided face to face.

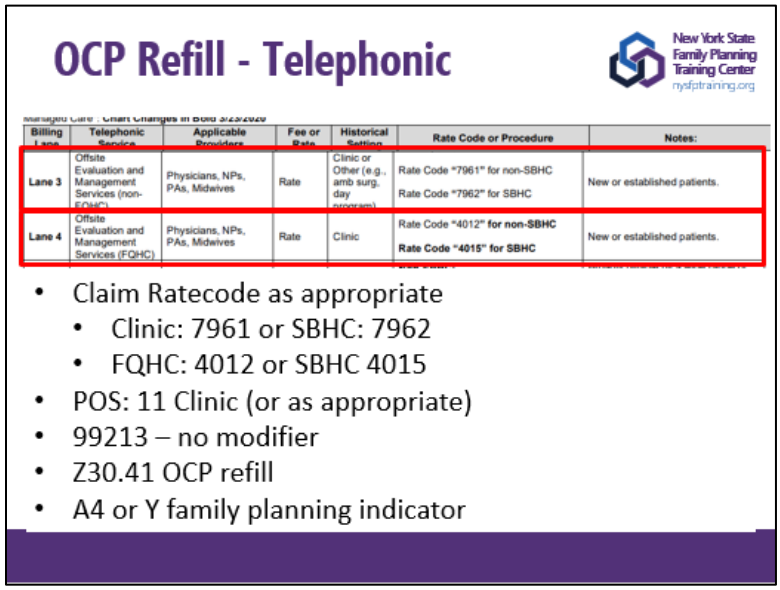


Ann Finn: They also said very clearly you don't need to use modifiers, those 95 GT and GQ that are for telemedicine, you don't need to use those for telephonic calls. The rate codes are going to drive the payment and you don't need to add these. That makes it simple.

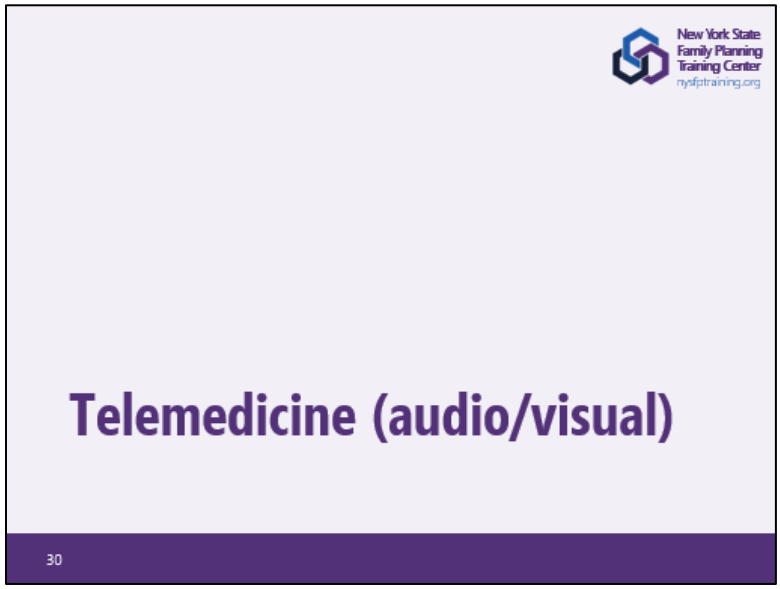
Ann Finn: Let's look at a scenario of a non COVID-19 patient in need of birth control calls in. Again, this is just a quick scenario to get us all on the same page. But Lisa is a 17 year old patient. She's at home, she's not able to connect with her audio/visual platform, so she's using her telephone for the visit with the nurse practitioner. She wants to obtain a refill on her oral contraceptive pills. Lisa receives patient-centered counseling and has all of her questions answered during 15 minute call.

The nurse practitioner sends a prescription renewal in for the pills. The provider documents a visit including the length of time spent with Lisa, and that they use the telephone to connect both Lisa and her location on the call and other relevant information for verbal consent, for example. Based on the face to face time normally used to select an ENM code, the provider could code a 99213. There's a lot of counseling time happening, basing it off of over 50% of the time is spent counseling and the total face to face time. It's easy to select some of those codes. We're also going to use Z30.41 and counter for surveillance or repeat

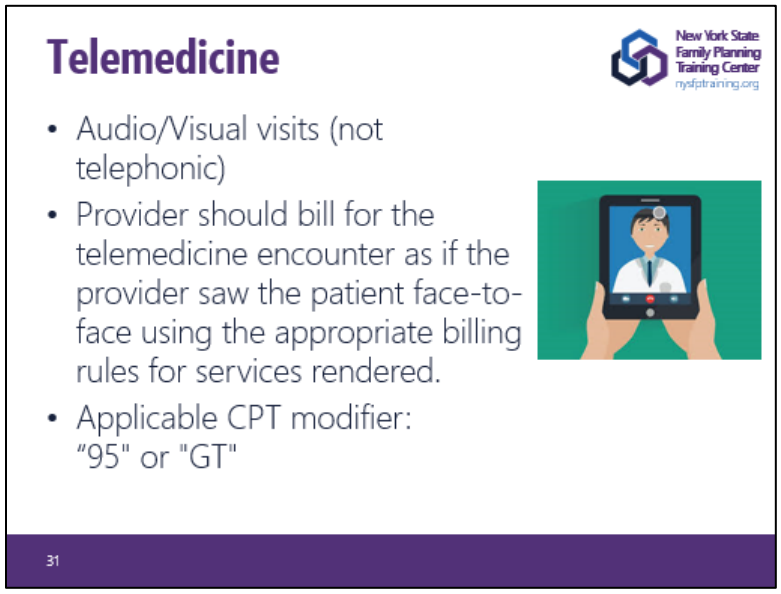
prescription on contraceptive pill as a diagnosis code.



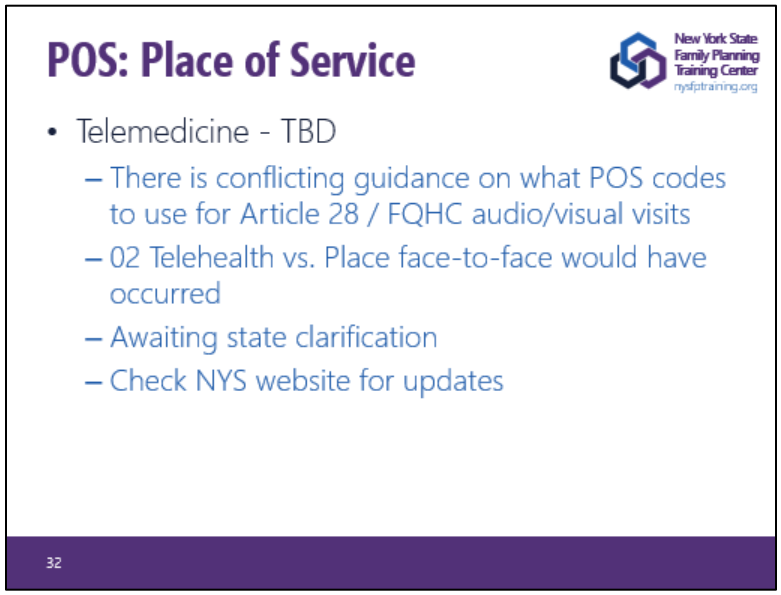
Ann Finn: Common scenario, I always think about how to bill it, so if you're a clinic, we're going to bill the rate code. We're going to have the ENM code, the 99213 nine nine with no modifier. We're going to say the place of service is an 11, the clinic or wherever, if you're would've been somewhere else normally, but clinic code, and we're going to have a Z30.41. We're going to have a family planning indicator because a Z30 is primary and then we're going to look to the rate code. If you are a clinic, you're going to bill 7961, and again it's not the CPT code that's going to drive the payment. It's going to be that all inclusive payment for the rate. If you are an FQHC, you're going to bill a 4012, and then again, if you have school based health centers under your facility, you want to make sure that they have the appropriate rate codes in the billing system. These are going to be the same for whether the new or established patients because it's rate driven, very code driven, and not CPT code driven. Then you'll get the same payment either way.



Ann Finn: All right, that's telephonic. That's audio only. So even if you have your smartphone, I even asked that question. Like, if you had a smart phone and you're using Skype, would that be considered the telephone? But it's, audio only. So, anything that has the audio/visual on the phone, is considered telemedicine. Okay?



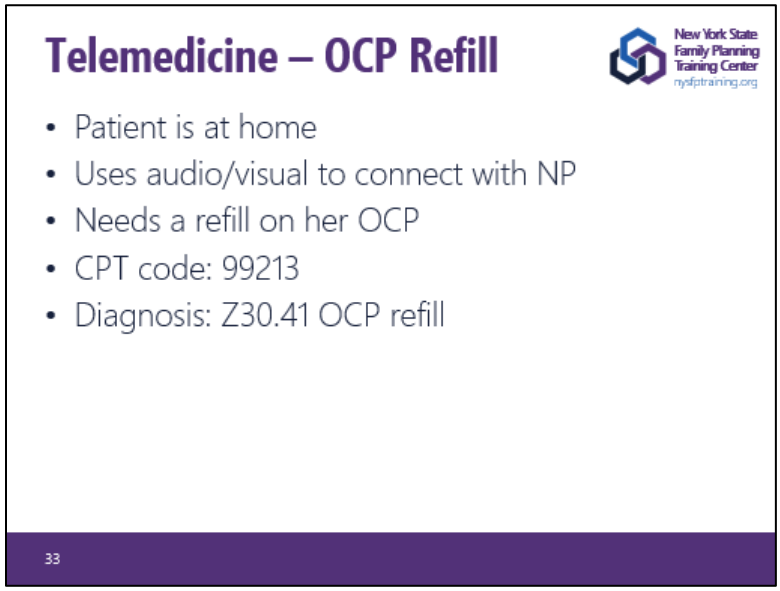
Ann Finn: And you'll see the terms, and I noticed this in the Medicaid updates, tele-health kind of includes both of them. Telemedicine typically refers to the audio/visual, and telephonic is the audio. I noticed there's a lot of interchanging of the terms, and it was confusing a little bit to me when I was trying to be very specific, because it talks about telehealth and telephonic, but telehealth includes the telephonic. And so, I think that's where some of the clarifications need to occur. Because telehealth would include the telephone, and they were trying to separate them. So it's telemedicine for the audio/visual, telephonic for the audio only. So when we're billing telemedicine with the visual, then we want to bill it the same as if the provider saw the patient face to face. And we're going to use the same CPT codes, and we're going to append the modifier 95, typically 95 or GT, depending on some of the specific codes that get used.



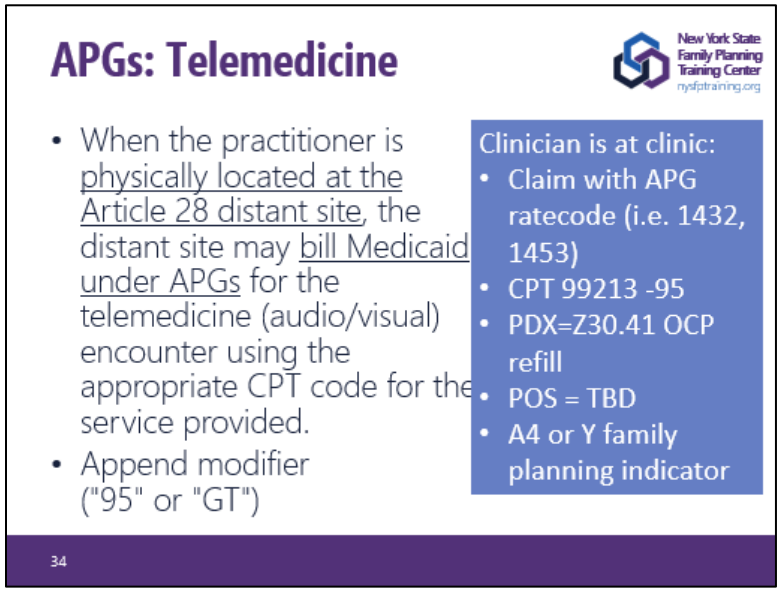
Ann Finn: So, for the place of service, this is one that was contradicting. And there was a few different things that were said in the FAQ and then, in some of my answers back, they were crossing out some of the guidance. So I'm going to leave this one up to that, we need to check with the updates that's coming out, to be clear. And typically, for telemedicine visits, you see the 02, for telehealth, used for place of service. But some of the

guidance also talks about, in the FAQs, being where the provider was located. Like 12, for their home. Or in the clinic. So, it was confusing, and you should check for the update. And then, we just want to make sure that those are put into our system correctly.

I really tried hard to get those answers, but I just thought at this point, with guidance coming out, it's better to flag some of the areas that are confusing to a number of different providers, kind of raise some of these questions. And where the state will probably provide some clarifying guidance, so it will be helpful to go through the updated documents, as soon as they're posted.

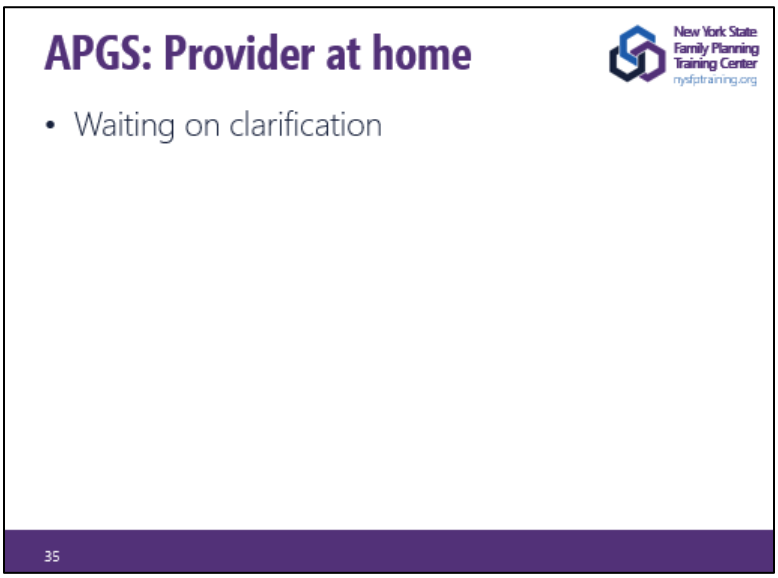


Ann Finn: Okay, so if you take the same visit with Lisa, and she is using the audio/visual system now. So let's say, she's on Skype with the clinic. Then, how are we going to bill for this visit? Let's see how it differs from telephonic.

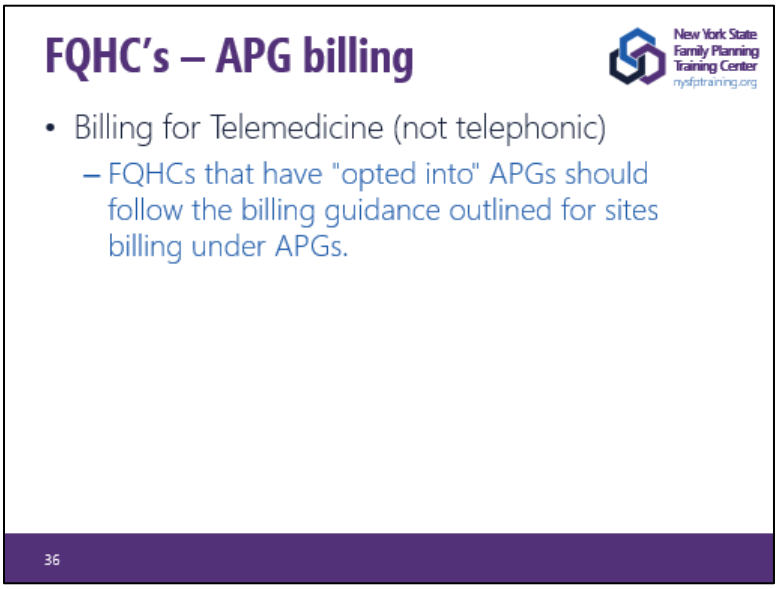


Ann Finn: So we are going to have the claim. If you're an APG biller, so if you're an Article 28 clinic and you bill APGs, then we're going to bill an APG claim. And we're going to use the APG rate code that you normally bill, for a clinic visit. You're going to have the same CPT code, like 99213, and add a modifier, 95. You have the

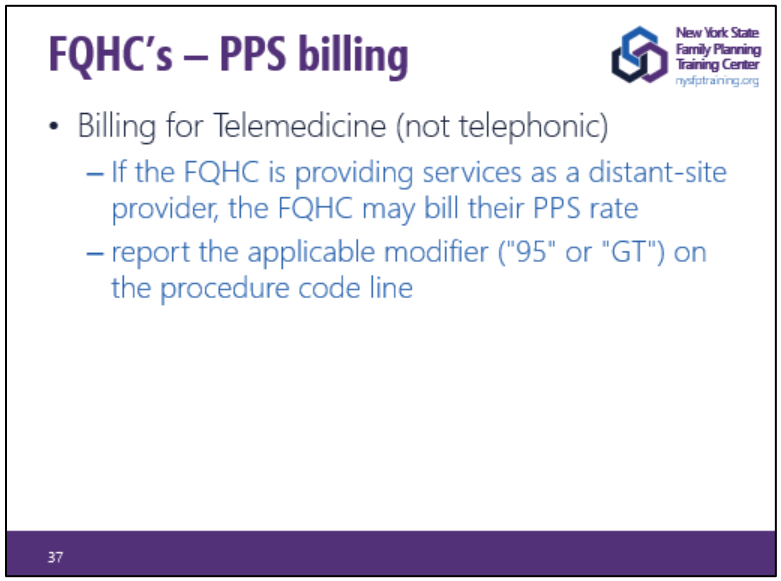
same diagnosis. Place of service, like we said, we're going to clarify that, hopefully this week. We're going to include a family planning indicator on the claim. And we're going to bill the APG claim, and the APG claim should pay as it did, as if it was a face to face visit.



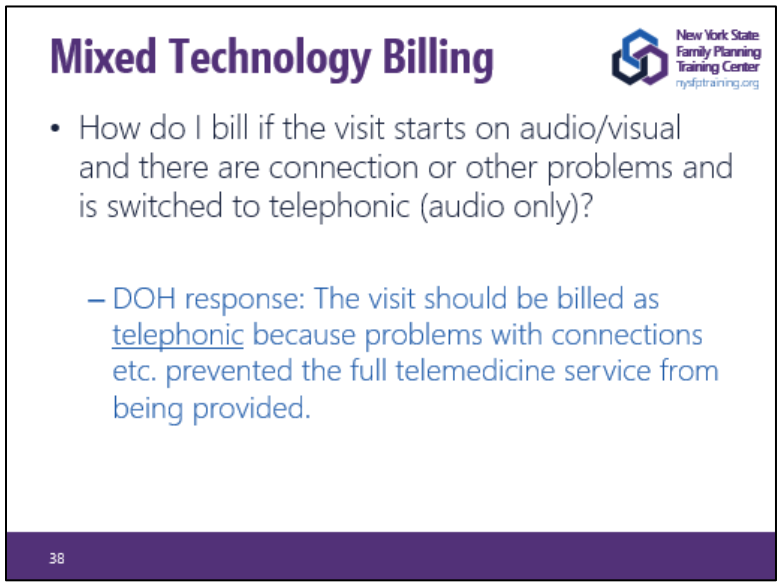
Ann Finn: What if the provider is at home? This was an area that was not clear, and there was some contradicting information and the way it was kind of posted, led me to think that it was suggesting billing in a way that would be paid less than a face to face visit. And the state said, they need to look at it, and kind of clarify billing for the home. At the home. So my thought is, and because these visits are supposed to be paying at the same rate as if it's face to face, that you'll probably still be billing the APG claim in the same fashion, as the provider was at the clinic. But. I want to wait for official guidance, for everyone.



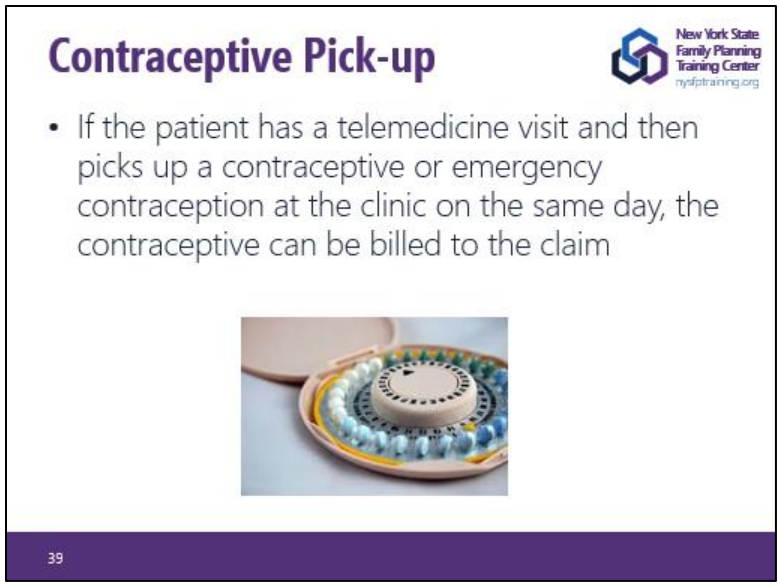
Ann Finn: If you're an FQHC, and you've adopted the APG billing methodology, then of course you're going to bill the same way that we just talked about, for the services when you're at the clinic or you're at home. And remember because the distant site where the provider is, is anywhere is covered, including the home. That's what leads me to think it's going to be the same billing, but, I'm just not sure on how that's going to work.



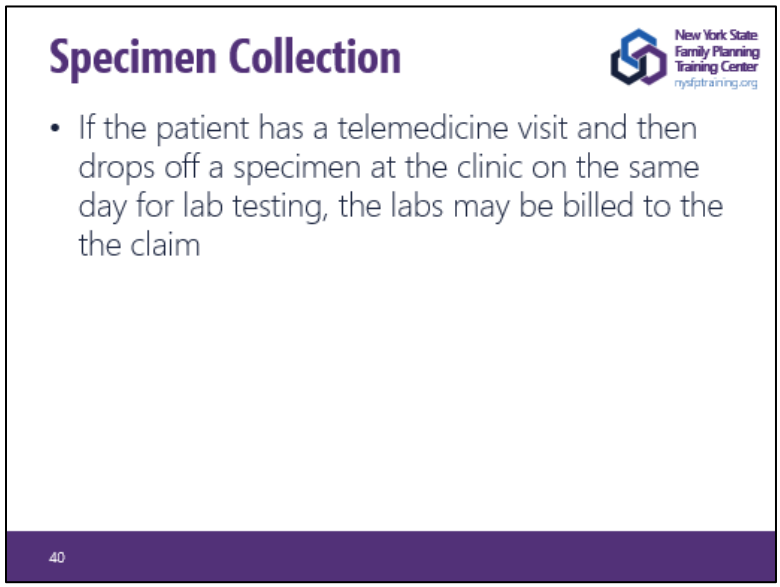
Ann Finn: Okay. For FQHCs, billing the PPS rate. So, you're billing a threshold visit, and not the APGs. If you are the distant site provider, the FQHC can bill their PPS rate, and you're going to do the same thing. You're going to bill for the CPT codes, you're going to add the 95 modifier, and you should get paid in full for the visit. So, the telemedicine audio/visual are kind of paying at a parity with the face to face visits, and the telephonic are being paid at parity with offsite E and M rate codes.



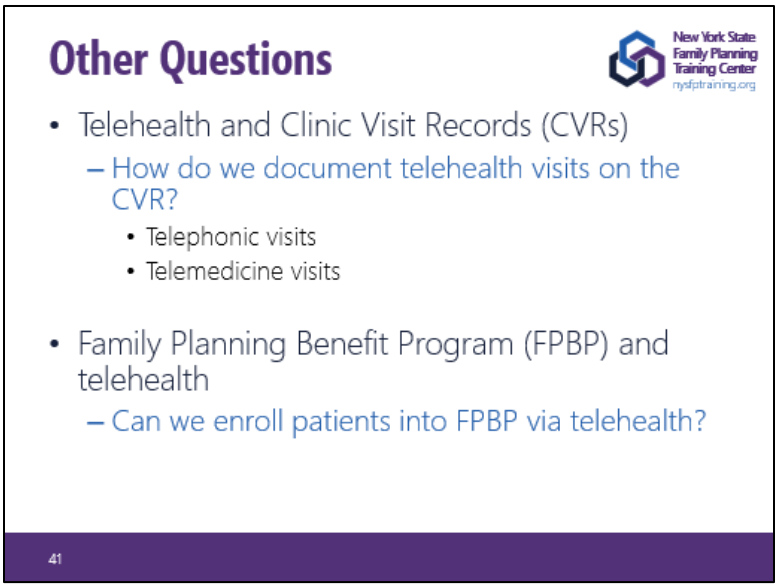
Ann Finn: So the question was asked, "What if the visit starts off as audiovisual, and there are connections and other problems, and then we switch over to the telephone, audio only. How do we bill for this service?" And it was funny, because the person said to me, "I think would bill this as an audio/visual call, as a telemedicine call." But the state came back and said, "No, it should be billed as a telephonic, because problems with the connection prevented the full telemedicine service from being provided." So, if you're switching during the middle of the call, then bill the way that you ended up, the platform that you ended the call with.



Ann Finn: Another question that was asked is, "What about picking up contraceptives? Can we bill for those?" So, the state clarified, yes, that if the patient has a telemedicine visit, and then picks up contraceptives or emergency contraception at the clinic on the same day, the contraceptive can be billed on the claim. So for those, if you're billing some of those rate codes that are all inclusive, if it's telephonic, that's not going to make a difference in your reimbursement. But if you're an APG biller, and you're billing telemedicine visits, then those services that are added on are going to trigger additional payments. Just like on the APG claim, face to face.



Ann Finn: About specimen collection, someone asked that, "What happens if a patient has a telemedicine visit, and then drops off a specimen? Can we bill for this?" And so, again, it's the same thing as with the contraceptives. If there is a telemedicine visit during the day, and then there some other services that happen, they can be billed for, as well. On the same day. Okay. It's a lot of information covered. And now I just want to turn it over to Rae Ann Augliera, who's the Assistant Director of the Bureau for Women, Infant & Adolescent Health, to talk about some other questions that came up. So thanks, Rae Ann, for taking on these topics.



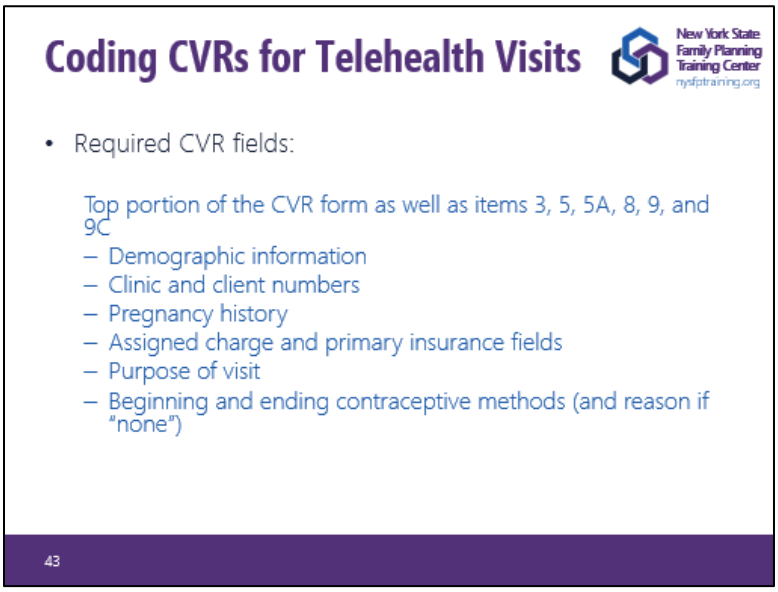
Rae Ann Augliera: Great. Thank you. So, we did want to take a few minutes to address some other frequently asked questions that have come through from New York State Family Planning Program providers. We did share last week that the visits conducted through telehealth can and should be documented in the clinic visit records, so that we're sure that we're capturing all of the information about the family planning services that you're delivering through telehealth, in our Ahlers data management system.

However, there were some questions about how specifically to document those visits, which we'll address in just a minute. And then, in addition, organizations that enroll patients into the Family Planning Benefit Program wanted to know, if the application can be conducted via telehealth. So, I'd like to turn it over quickly to Eileen Shields, the Director of our Data Analysis Research and Surveillance unit, to respond to the first question and provide some more information about how to code your CVRs for your telehealth visits.

Eileen Shields: Thanks, Rae Ann. And good afternoon, everybody. You should all have received an email earlier today with the information that is going to be in the slides. It was a little more details, but I just want to briefly go over some of the most important points. As Rae Ann said, and has been documented previously, there is no field in the CVR for specifying telehealth visits. So you code the visits the same as a CVR for an in person visit, as

best you can. Please review the email that was sent earlier with coding specifications and specific examples. And also, please read additional telehealth related documentation, and other sources.

Let our program know about the telehealth work you're doing, and as time permits, please track those visits with any related issues and successes that you're experiencing. And, given the documentation requirements that Ann noted earlier, for your Medicaid records, we might be adding a small request for additional information in your quarterly reports. And please, always remember, you can reach out with any questions to your FPP program manager here, and please cc any emails to our BML.

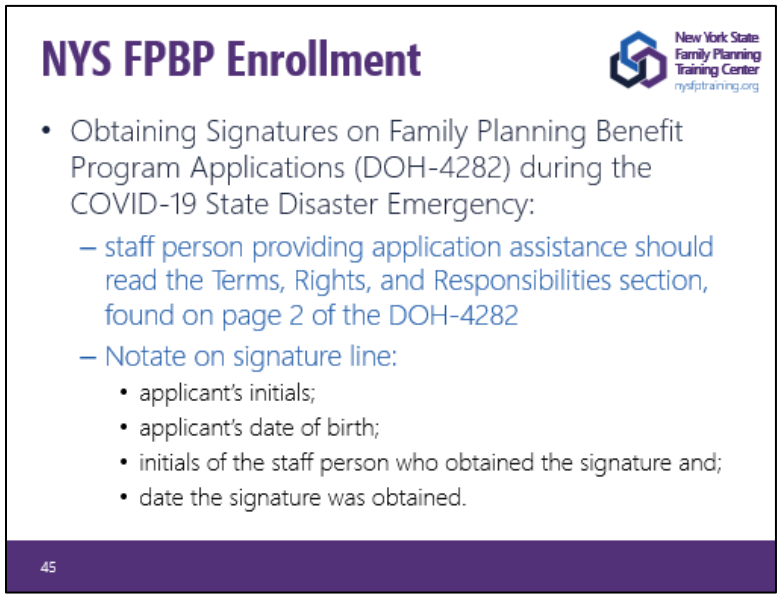


Eileen Shields: Just to go over, in brief, the required information on the CVRs. All of the top portion... Just let me add that, you should have received a copy of the CVR with the email this morning, as well. Everything in the top portion is required, with the exception of the Medicaid number. That is only required if you use Ahlers for your Medicaid billing.

But, in brief, it's all the demographic information, the clinic and client numbers, pregnancy history. And then, the other required parts are in the lower section of the CVR. And those are items 3, 5, 5A, 8, 9 and 9C, including the assigned charge and primary insurance fields, the purpose of visit. Visit date is not listed in this slide, but that's very important. And, the beginning and ending contraceptive methods. And reason, if none.

Eileen Shields: Additional visit specific coding, of course will vary, depending on what services are provided and communications capacity. But may include medical services, counseling services, pregnancy testing and STD, testing and treatment. Those are most important for... Most importantly for those, they must be accompanied by family planning related counseling and education, particularly for new clients.

You also will be coding type of provider and type of counselor, depending on which of the above services you provide. The email, again, includes more specific examples and further guidance, so please review that carefully. And again, please feel free to contact any of us here in the department for further assistance, if you have any additional questions. I hope that's helpful. Thank you.



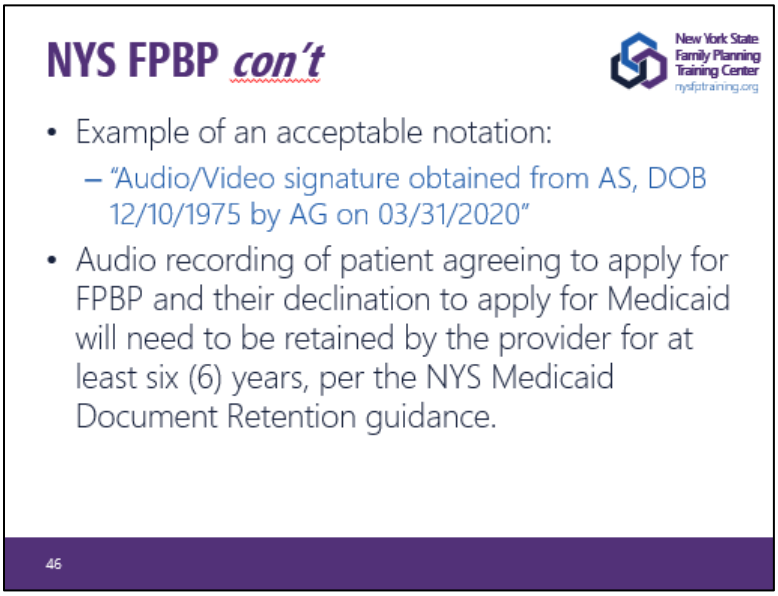
Rae Ann Augliera: Thanks, Eileen. And just to echo what Eileen mentioned about the email that went out earlier today, I believe that was sent out just prior to this call. And it was sent to specific contacts on our Family Planning Program listserv. So if you, whoever in your organization is designated as a program director, clinical contact, physical contact or executive contact would have received that guidance. So, if you haven't seen it yet, please reach out to those in your agency that are on our listserv, and they should have that guidance to review more fully.

Rae Ann Augliera: Moving on to the other questions that we've received. We have also been asked whether Family Planning Benefit Program Applications can be conducted through a telehealth visit. And the answer to that is yes, Family Planning Benefit Program applications, including the presumptive eligibility screening forms, can be conducted during your telehealth visits. Our colleagues in the Office of Health Insurance Programs sent guidance out on April 2nd that went to individuals on the Family Planning Benefit Program listserv, so that guidance is summarized here on this slide and the next slide.

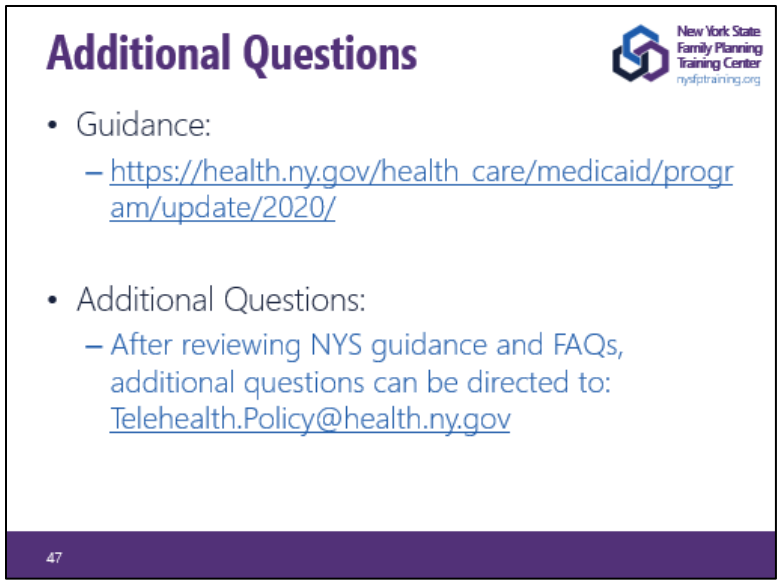
They did make clear to us that applications are still being processed, as they always have been. Both for PE, and for the full FPBP application. So, those are still occurring, and certainly would like for, to the extent that you can, for you to continue to do those applications in conjunction with a telehealth visit with your patients that need insurance coverage.

So, the summary here on this slide, the guidance predominantly relates to how to obtain signatures during this COVID-19 Emergency. And the guidance specifies, it's specific to the Family Planning Benefit Program, the full application. So, of note is that, the staff person that's providing the application assistance, they should read the Terms, Rights and Responsibilities section to the patient. And, also need to read the Declination of Medicaid Eligibility Determination section, to the patient.

So, this is how we're going to obtain the consent of the patient to apply for Family Planning Benefit Program. In addition, the staff person providing the application assistance should make a notation on the signature lines of the application to indicate the applicant's initials, the applicant's date of birth, the initials of the staff person who obtained the signature, and the date the signature was obtained.



Rae Ann Augliera: Here you can see an example of an acceptable notation. In addition, there's an audio recording requirement for the patient agreeing to apply for the FPBP and their declination to apply for Medicaid. That needs to be retained by the provider for at least six years per the New York state Medicaid document retention guidance.



Rae Ann Augliera: Again, our colleagues in OHIP have indicated that additional guidance is forthcoming that will allow for some easements of documentation that will further simplify and support the FPBP application process during this emergency. So keep an eye out for that coming from the FPBP listserv. And if you're not on the FPBP listserv or you have any other questions around Family Planning Benefit Program enrollment during this time, please feel free to reach out to the staff at OHIP and use their Family Planning Benefit Program email address for those questions. That email address, if you don't have it is FPBP@health.NY.gov. And I think that is it. I'll turn it back to Anne for additional questions.

Ann Finn: Great. And so, again, just wanted to say that here's the link at the top. This is where the Medicaid updates are located, and if you have additional questions about the telehealth billing, then you can send it to the email box on the slide here, telehealth.policy@health.NY.gov. Okay. We have questions.

Can providers bill for asynchronous telehealth? Yes, they can bill for those types of visits. Those visits are like store-and-forward where they're not in real time. And in the Medicaid update that I just gave you the link to, that volume five, it starts on page four and talks about billing for this service. And then on page nine it talks about the reimbursement for store-and-forward billing and how it works. And there's also remote

monitoring of patients' vitals and other information that's needed for diabetics and other conditions, and that's covered as well. That's in the state's guidance that'll go over that and give you some of the specifics on it.

What type of service do you use to bill 99441-99443? So for the 99441 to 99443, the state was very clear that they said that was only for office based billers that are billing the professional claim, not the facility billing. So they said you shouldn't be using the 9944 codes. You should be using the E&M codes as appropriate that the provider would normally be coding the 992 codes.

Do managed care plans pay an FQHC, the offsite rates, the telephonic visits? You have to kind of check with your managed cares just to make sure I'm what they're doing. But they should be kind of following the fee for service guidance according to the update and paying that same offsite rate just like fee for service is doing. So I would expect, yes, but again you should clarify with the different payers. And really make sure if there's any specifics that they want to see such as modifiers or place of service codes. Any of those kinds of nuances, we want to make sure you go through your payers and have got that all configured out so that we don't miss-bill the information and end up with a denial.

Where can I find the new updates on Telephone billing that clearly state that the Place of Service (POS) should be where the face-to face encounter should have happened and the CPT codes should be the regular E/M codes? If you go through the FAQ, things are stated a few different ways. This came to me last week from OHIP and from the people in charge over there, and they said that they are updating the guidance and it'll clearly say that. So they said the guidance is coming out timely, so I kind of just checking even today, but I didn't see it yet, so I would imagine this week. But I'm not sure.

Can the provider bill the PPS rate if they are providing services from home to a patient who is also at home for audio/visual services? Again, both for those homes, the guidance was not super clear and I posed those direct scenarios over to OHIP. I've said APG biller, practitioner at the office, APG biller, and practitioner at home, just to make sure we are clear.

And I know a couple of other people ask those same questions FQHC with the provider in the clinic or at home, and they said they were going to clarify. They said they couldn't clarify until they put the guidance out. So I think that they were working on it. So I'm sorry to not be clearer. But be on the lookout for that and I think it will address those questions pronto, hopefully this week.

Can you provide any guidance on appropriate counseling CPT codes? Well, depending on the service, there's different counseling code that are different types of providers, like dieticians, nurses, or social workers would use. So you'd use those same CPT codes that they would normally use, but things like 99401, some of the preventive medicine counseling, those can be used. Really any of the CPT codes that describe the services that you provide face to face can be billed as telemedicine. Because the nurses are allowed to bill in lane five, I would imagine 99211. It would cover some of the grief services that they would be providing. And then providers that are doing counseling, you would still bill the E&M code, the 992 codes, for their counseling.

Katie Quimby: There've been a few questions about FPBP, so maybe I can see if New York State Department of Health has the information to answer those few questions that we've received. Otherwise, we can bring them back to OHIP to answer.

Regarding the audio recording for the consent for FPBP application, has there been any guidance about how to obtain that audio recording? No specific guidance, and I think that that would vary depending on what platform you're using for the encounter. It could be different. So what we do know is that the forthcoming

guidance from OHIP about documentation is going to allow for some easement of documentation and we'll show some other options available if recording the patient encounter isn't possible. So I would just keep an eye out for that guidance to come out from the FPBP staff at OHIP.

To confirm, *the audio recording of the patients agreeing to apply for FPBP is a requirement, correct?* That is currently a requirement. So I'm not sure what the new guidance is going to say because I think, as, as people are concerned about whether the platform that they have will actually be able to maintain that for the required six years. So I would just keep an eye out to learn what kind of easements they're able to put in place to allow for other options.

Are you aware of any current plans for extending FPBP applications during this time? I'm not aware of that. We can take that back and ask folks.

Can presumptive eligibility for FPBP be over the phone? Yes.

Katie Quimby: So we can give it a couple more minutes to make sure we've received and answered all of your questions, for the questions that we can answer today. And not seeing any other questions coming in. Ann, any last comments from you before we sign off here while we're wrapping up?

Ann Finn: Just to check that Medicaid guidance and check it this week and there'll be an update, but check it for ongoing because I think as COVID-19 continues to develop, the guidance, and as people are starting to bill for this, there's going to be clarifications out there. And then, again, check with your other payers, your commercial and your managed care plans, to make sure that you've picked up all of their requirements and get those claims in. And don't forget, you still got to do a timely billing, timely filing, and get those claims in. So we really want to get these systems set up and get these rate codes loaded in so you can bill for them.

Katie Quimby: That brings us to the end of the webinar. So thank you all very much for joining us today. As you log out from the webinar, you will be prompted to complete an evaluation. We do sincerely ask that you fill out that evaluation for us and let us know what you thought of today's webinar and how we can improve. We always use your feedback to improve future webinars, so please take a minute and share your thoughts. Thank you all so much for joining us. Thank you for your questions. That concludes today's webinar. Thank you. Have a great day.