UL Health | Telehealth

CMG TELEHEALTH

Practice Manager's Guide

MARCH 19 - JUNE 30, 2020

APRIL 6 2020

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CMG Guide

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rev. 4/5/20

TELEHEALTH INITIATION FACT SHEET
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NOTE: The upcoming Epic implementation will include a robust telehealth solution. The current process is in place in the meantime. The setup process is very quick, assuming no unusual circumstances require legal review.

1. Complete the top box of the **Telehealth Project Initiation Form** and email to **telehealth@ulp.org**
2. Telehealth Project Initiation Form will be completed and circulated through UL Health and copied to department, followed by project implementation (1-3 business days).

UL Health Telehealth Facts

TECHNOLOGY

- BlueJeans is currently the only compliant technology for outpatient telehealth in UL Health. Institutional license covers all expense for usage. BlueJeans can be accessed via PC, tablet or mobile device.
- Additional technologies may be utilized on an urgent basis, as communicated by Telehealth Task Force.
- Inpatient telehealth requires special consideration at this time. UL Health does have technology for these purposes.
- Services may be rendered by telephone if telehealth is not possible or not indicated. Services must be documented and verbal consent must be established (see Telemedicine Consent documents). Please refer to coding and description list provided in the Practice Manager's Guide for specific coding.
- Interpreting services are available for the telehealth appointments.

COMPLIANCE

- Insurance authorization and patient consent are required for telehealth. Consent form can be signed by patient electronically. Verbal consent is permitted (see Telemedicine Consent documents).
- For the duration of the COVID19 situation, CMS has permitted licensed providers to treat patients in any state. Please refer to the AAMC Medicare/Medicaid Policy Response (provided in the Practice Manager's Guide) regarding resident and fellow changes.
- In Kentucky, a "parity" state, commercial payors must reimburse at the same rate for a telehealth service as an in-person service. Kentucky Medicaid follows this. Effective March 6, 2020, Medicare has waived all reimbursement restrictions for telehealth services in response to COVID-19.
- Telehealth services must be billed under Place of Service 02.
- Practices **MUST** use Telemedicine Appointment Types:
  CMG – "Telehealth Visit, "
  AMG – "Telehealth 30/60, T30/T60"
- Residents may perform telehealth services in coordination with their Attendings, following the CMS Guidelines for Teaching Physicians, Interns, and Residents.

PROVIDER EXPECTATIONS

- Provider documentation must be completed within 48 hours of telehealth service in Kentucky.
- Provider documentation needs to include a statement citing that the service was performed by telemedicine using audio and video technology (or telephone, if Telephone Service), and noting both the patient's and provider's locations at the time of service.
- Provider should conduct telehealth visit with the same etiquette as an in-person visit. Professional dress and background are indicated. Interruptions such as phone calls should be avoided.

UL Health TeleHealth Contact List			
Name	Position	Email	Phone Number
TeleHealth Service Account		Telehealth@ulp.org	
Request TeleHealth Hardware		Telehealth@ulp.org	
Debbie Edison	AVP Revenue Cycle	Debbie.Edison@ulp.org	(502) 588-0331
Ellyce Patton	Director of Operations Neurosurgery	Ellyce.Patton@ulp.org	(502) 588-4788
Kent Gardner	Director of Instructional Technology	Kent.Gardner@louisville.edu	(502) 852-2778
Krista Kane	Executive Director Neurology	Krista.Kane@ulp.org	(502) 751-0888
Rob Caudill, MD	Director, Telemedicine for Psychiatry	Robert.Caudill@louisville.edu	(502) 588-4450
Martin Kaelin	AVP Technology	martin.kaelin@ulp.org	(502) 588-0467
Shelly Denham	SVP, Compliance, Risk, & Audit Services	Shelly.Denham@ulp.org	(502) 588-4520
Tim Bickel	TeleHealth Director	Tim.Bickel@louisville.edu	(502) 777-9306
Wade Mitzel	COO ULP	Wade.Mitzel@ulp.org	(502) 588-4289

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UL Health User Requirements

Equipment

UL Health IT will conduct a thorough audit of current equipment (and what is needed) to be used for Telehealth visits.

1. Internet enabled device for provider
(computer w/ webcam, android or iPhone, tablet, etc.)

2. Desktop or laptop computer for office staff

3. Headset for office staff

Important Note: If a new computer is deemed necessary, please ensure the intended user logs in at least once while on the network, prior to taking the device to an offsite location. Otherwise, the user will not be able to use their computer; it will not take their credentials.

BlueJeans Operating System

Additional specifications for BlueJeans can be found at their support website.

- Windows - 10 & 7 (with SP1+)
- macOS - 10.11+
- Linux - RHEL v7.5, 7.6, 8.0, Fedora 28, 29, 30, CentOS 7, 8 and Ubuntu 18.04, 19.10

BlueJeans App Specifications

- Minimum supported iOS version is 11.0 and later
- Please connect to a wi-fi network for the best quality

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Remote Telehealth Worker Checklist:

We are seeing several technical roadblocks for providers who are attempting to work on telehealth sessions remotely. This checklist will make sure that the user is ready and capable of functioning when they are off campus.

- If the provider is taking a laptop, they must log in to that laptop at least once on campus to cache their credentials. If this is not done, they will not be able to log in at home.
- Does the user have Duo set up? If not, they will need to register for it while on campus. (CMG users cannot call CHI helpdesk for this. This must be done on campus.)
- Does the speaker or microphone on the device work? Do they have a headset (optional, for additional privacy)? These should be tested before leaving campus.
- Has the user logged in to Citrix and are they familiar with the process? Do they have the icons that they need available in their Citrix portal? (CHI, ULH, and ULP all have their own portals.)

    - CHI Portals
        - Webapps.catholichealth.net (majority of the Citrix based applications)
        - Mychiwebapps.catholichealth.net
        - Cerner.catholichealth.net
        - Allscripts.catholichealth.net

    - ULH Portal
        - Cerner.ulh.org

    - ULP Portal
        - Citrix.ulp.org

Please send questions or concerns to telehealth@ulp.org. Thank You!

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UL Health Telemedicine Frequently Asked Questions

Okay, my group is ready to start seeing patients via telemedicine, what do I do first?
The very first step is to fill out the **Telehealth Project Initiation Form** and email to **telehealth@ulp.org.**

Where can I go to get more information on TeleHealth at UL Health?
Email the TeleHealth service account and ask for more information. The service account is **telehealth@ulp.org**.

What is the software used for Telehealth visits and what is the cost?
Currently UL Health is utilizing BlueJeans. This platform is a HIPAA compliant and approved by the University of Louisville and UL Health. This may be subject to change due to the ongoing changes with UL Health EMR. BlueJeans is free to use due to the amount of licenses UofL has already purchased. As mentioned above, this is subject to change as UL Health updates their EMR systems and software offerings.

Is it compliant to use BlueJeans on a personal smart phone?
UL Health Staff should schedule patients through the web browser application. Providers can use their personal device to conduct visits; however, UL Health will not be able to provide technical support if any issues arise.

Are any other platforms approved by UL Health for video conferencing?
At this time, no. BlueJeans is the only UL Health approved platform for TeleHealth. Providers may be able to use other teleconferencing platforms on an urgent basis, as directed by UL Health Telemedicine Task Force.

It appears that Clients are first seen in the office to get information/instruction/consents for Telehealth, then subsequent appointments can be done via Telehealth. Do the Telehealth clients also need to have a future in-office visit or do they remain on Telehealth visits?
Many telemedicine patients are seen in the clinic first; however, this is not mandatory. Patient consent is required prior to seeing the patient via telehealth (see Telemedicine Consent Forms).

Is the utilization outside of office hours or only during office hours?
Due to the current limitations of the system and staff, UL Health Telemedicine can only be provided during regular office hours.

Will my Telehealth visits be discounted by insurance companies because I did not see the patient in person?
No. In Kentucky, a "parity" state, commercial payors must reimburse at the same rate for a telehealth service as an in- person service. Kentucky Medicaid follows this. Effective March 6, 2020, Medicare has waived all reimbursement restrictions for telehealth services in response to COVID-19.

Are the requirements for billing the same as office outpatient visits, if not what is the criteria?
YES - see above comments. Telehealth services must be billed under Place of Service 02 to identify the encounter as telehealth.

My patient needs a translator; do we offer these services for telemedicine visits?
Yes. Many translation services are adapting their practices as well. The clinic staff will contact the translation service and coordinate this service for the appointment.

In December 2020 when EPIC transition starts how will this new telemedicine system be affected? This has yet to be determined. UL Health is working with various platforms to identify the best Telehealth solution for EPIC.

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TELEHEALTH: CMG PROCESS FLOW

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CMG Outpatient Appointment Checklist

- Location and Template created in Allscripts
- Create Macro in Allscripts with Telemedicine consent documentation
- Appointment scheduled in Allscripts on provider's existing schedule, USING TELEMEDICINE APPOINTMENT TYPES
- Patient phone/email/insurance confirmed in PPMS
- Telemedicine process explained to patient
- BlueJeans instructions emailed to patient
- Insurance authorization complete (VEVC)
- Medication/Allergy/Problems Reconciliations complete
- Copay collected
- Contact appropriate interpreting service to obtain email to send telehealth visit (if necessary)
- Appointment meeting scheduled in BlueJeans
- BlueJeans link send to patient and provider
- Verbal/written consent obtained
- Provider sees patient via BlueJeans
- Provider documents encounter in EMR with telemedicine statement
- Provider signs note

UL Health TeleHealth Visit Set-Up

3/2020

Practice Manager

- Fills out Project Initiation Form
- Sends Project Initiation Form to TeleHealth Service Account

Physician

- Identifies need for TeleHealth Services
- Initiates Patient Visit per Schedule

Scheduler

- Schedules Patients
- Verifies Patient Access to equipment and provides training
- Sends visit to proper staff to start VEVC process

TeleHealth Team

- Reviews Project Initiation Form for completeness
- Schedules Conference Call regarding GoLive Timeline. Call will include IT, TeleHealth Committee, CBO, Practice Manager
- Trains Provider
- Trains Staff

UL Health CBO

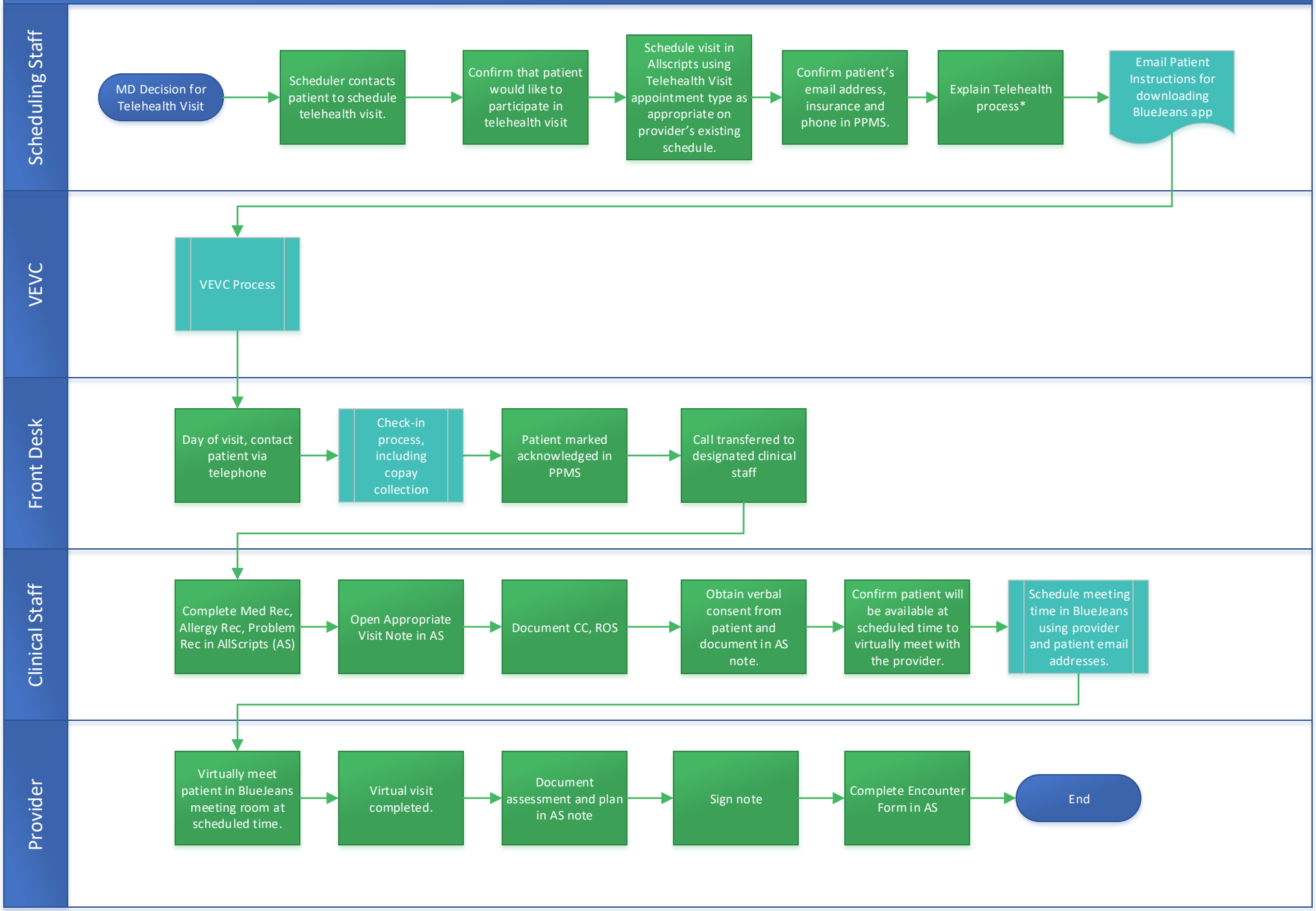
- Meets Billing requirements
  - Yes → Confirmation email to TeleHealth Committee
  - No → Rectify issues/ add billing requirements

UL Health IT

- Confirm equipment requirements
  - Yes → Confirmation email to TeleHealth Committee
  - No → Rectify issues/add IT requirements

Telehealth-BlueJeans 3.19.20-6.30-20

CMG COVID-19 Workflow



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revised 4/5/20

Telehealth Scripting: Established Patients

Cancelation of Appointments due to COVID-19
Thank you for giving us a call to cancel your appointment. We are now offering telemedicine services. This will allow for you to see your provider over the phone using an application called BlueJeans. This application is a lot like Skype, Facetime, Facebook Messaging; however, it is HIPAA compliant. The application is free and can be downloaded on your smart phone or desk top. Is this something you are interested in?

(If patient says yes) Great. What device are you considering using?

Okay. I can walk you through the process to download the application now, if you'd like. Or I can email you the instructions if you'd like to do it at another time. If you are going to download at another time, we do ask that you test your device prior to the visit to ensure no issues at the time of the appointment.

If walking through download process:

(*Smart phone/tablet: use smart instructions on how to download app*)

(Desktop: use desktop instructions on how to download) Before I begin to walk you through the instructions on how to download the application onto your desktop, could you please confirm you have a webcam or built-in camera for your desk top?

(if confirms, proceed with desktop instructions)

(if says they do not, suggest downloading app on phone and/or tablet)

Please let me know once everything is downloaded. I will also be emailing the packet of instructions for you that include IT support contact information and a copy of the instructions we just walked through. I will also be sending you a consent form we will need you to fill out, sign, and send back 48 hours prior to your visit. Please provide me with an email I can send this information to.

(patient provides email)

Thank you. Is this also the email I can send the Telemedicine appointment calendar invitation?

(confirms or provides different email)

Great. Thank you. Please feel free to call our office at least 24 hours prior to the visit if you need to reschedule.

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revised 4/5/20

Telehealth Scripting: Established Patients

When we do not have an appointment within 2 weeks (or as soon as the patient would like to be seen)

Hi Mr/Mrs.___ . The next available clinic appointment isn't until _____. We are offering appointments via Telemedicine. This will allow for you to see your provider over the phone using an application called BlueJeans. This application is a lot like Skype, Facetime, Facebook Messaging; however, it is HIPAA compliant. The application is free and can be downloaded on your smart phone or desk top. Is this something you are interested in?
(If patient says yes) Great. What device are you considering using?
Okay. I can walk you through the process to download the application now, if you'd like. Or I can email you the instructions if you'd like to do it at another time. If you are going to download at another time, we do ask that you test your device prior to the visit to ensure no issues at the time of the appointment.

If walking through download process:

(*Smart phone/tablet: use smart instructions on how to download app*)

(Desktop: use desktop instructions on how to download) Before I begin to walk you through the instructions on how to download the application onto your desktop, could you please confirm you have a webcam or built-in camera for your desk top?

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(patient provides email)

Thank you. Is this also the email I can send the Telemedicine appointment calendar invitation?

(confirms or provides different email)

Great. Thank you. Please feel free to call our office at least 24 hours prior to the visit if you need to reschedule

Telemedicine Standard Work/Role Expectations Example

Scheduling Staff		
Scheduling in Centricity	Clinical staff/MD request a telehealth visit	
	Use Telehealth visit types	T30/T60 for AMG, Telehealth Visit for CMG
	Schedule on provider's existing schedule	If an ad hoc slot is needed, follow usual process for having a slot opened.
	Use reason and comment fields as if a clinic visit	Consider also adding TELEHEALTH to further call out the unique visit type on the schedule.
	Interpreters	This workflow is TBD as of 3/22/20. Do not schedule a person who needs an interpreter until this workflow is established.
Patient Communication	Confirm the patient desires a telehealth visit.	Copay/Coinsurance/Deductible will apply.
	Confirm the patient has access to a computer, tablet, or smart phone with high speed internet.	If internet is not available, a telephone call can be used in lieu of the virtual visit. Note that in the appointment comments.
	Confirm the patient's email and telephone	It is imperative that the patient's active email and phone be confirmed in Centricity
	Explain the telehealth process.	1. Appointment is scheduled. 2. An email will be sent with patient instructions for downloading the BlueJeans platform for the virtual visit. 3. The patient needs to be available via phone the day of the visit for registration and medical triage activities. 4. The Front Desk staff will call the morning of the visit to confirm insurance and collect the copay (credit card payment) over the phone. 5. The Medical Assistant will review clinical information including medications, reason for visit, etc. 6. Once the copay is received and the MA has completed the triage process, the MA will send a link to the BlueJeans "exam room" via email. 7. At the scheduled time of the appointment, the patient will enter the virtual exam room and meet with the provider. They will have audio/visual communication. 8. The patient's insurance will be billed, just like an in-person visit to the office.
Email Instructions	Email the Patient Instructions.	Use your ULP/ULHealth email to send the "Patient Instructions on how to download" PDF. The body of the email will be constructed by practice leadership to confirm the appointment time and the Telehealth process. This standard format can be used (copy/paste) for all telehealth email communications to patients.

Visit Eligibility Verification Coordinator		
	Follow established VEVC process for the practice	Take note of Telehealth appointment types and check for telehealth services on the plan. Some commercial plans may not have telehealth services. During the time of COVID-19, CMS has relaxed all guidelines. We anticipate the Medicaid and commercial payors will follow suit. We will continue with the telehealth visits and collect copay/coinsurance/deductible per our established process.
Front Desk		
	The morning of the telehealth visit, all scheduled telehealth patients will be called for registrations, copay/patient liability collection, and Arrival in Centricity.	Good communication between the Front Desk and Clinical Staff will be required to make one efficient and effective phone call to the patient. This process will be completed in the same manner as face-to-face presentation to the clinic, the only exception is the communication will be over the phone.
	Follow established POS and Arrival process.	
	Once "Arrival" is completed, transfer patient to designated Clinical Staff.	Some practices will use the clinical staff assigned to the provider, Triage staff, or another resource. Work with Practice Leadership to determine who this person is. Be sure that the Clinical Staff is finished with the call before working the next telehealth visit. We don't want to call our patients and then place them on hold.
Clinical Staff		
	Received transferred call from Front Desk.	
	Complete Allergy Rec, Med Rec, Problem Rec.	These are required for Meaningful Use and should be a part of all clinical notes.
	Open appropriate note in AllScripts.	The AS team is working on a telehealth note, but until that is completed, open the note that is most appropriate for the patient's visit assuming he/she would be visiting the clinic.
	Document Chief Complaint.	
	Obtain verbal consent.	Telehealth visits usually require a written consent to be on file. During the COVID-19 pandemic this requirement was relaxed to allow verbal consent. The wording for the consent is standard and has been approved by UL Health Legal. The consent wording should be copied and pasted into the AS note. This consent should be read to the patient in order to obtain and document agreement, and all blank fields should be completed as appropriate.

	Confirm that the patient has downloaded the BlueJeans App and he/she will be available at the scheduled time.	These instructions were sent via email by the scheduler at the time of appointment scheduling.
	Tell the patient to watch their email for a meeting invite from BlueJeans.	Instruct the patient to call the clinic if they do not receive this invite.
	Schedule the visit in BlueJeans.	Follow the Quick Start Scheduler Instructions for Creating Appointments in BlueJeans. Send the invite to the provider's email address and the patient's email address. If the provider requests a scribe, the MA can also join the virtual exam room by sending an invite to his/her email as well.
Provider		
	Work with your clinical staff to determine who is a viable telehealth candidate and instruct scheduling parameters.	
	The appointment will be shown on your AllScripts schedule.	
	You will receive a meeting invite to your email/Outlook from BlueJeans	This will include a link to the meeting. There is a unique meeting room number and passcode assigned to each appointment.
	Be sure you have access to a computer with a webcam.	Most ULP laptops have a built-in webcam.
	At the scheduled time of the visit, click the link in your email/calendar invite to connect with the patient.	Using a headset, or taking the visit in a private room is recommended. Use of your office with a closed door, or an empty exam room would be ideal.
	Document your assessment and plan in the opened AllScripts note as you would for an in-person office visit.	
	Complete and sign your note within 48 hours.	48 hours is a government requirement for Telehealth.
	Submit E/M codes 99201-99215 as appropriate with your documentation.	The Place of Service is 02, Telehealth. Currently the CBO has TES edits on the backend to catch these claims based on the Telehealth visit type that will assign the appropriate place of service.
	Instruct your clinical staff if/when you would like to see the patient again.	Be sure to communicate if the patient needs telehealth or face-to-face for subsequent visit.

******The use of the BlueJeans platform is temporary. We will move to use of the Epic telehealth platform at the end of 2020******

U of L Health Telehealth Visit Confirmation

Sherri B. Ryan <sherri.ryan@ulp.org>

Wed 3/25/2020 2:25 PM

To: Ellyce Patton <ellyce.lipper@ulp.org>

Ellyce Patton
DOB

The above patient has been scheduled for a telehealth visit with **Dr. Darryl Kaelin** on **Monday 4/6/2020 at 2:00 pm**.

On the morning of the appointment our office staff will call you to verify insurance information and collect any required copayment or coinsurance. You will then be transferred to one of our Nurses or Medical Assistants to review your medications, health history, and our consent for a telehealth visit. At the completion of the call you will be sent a meeting invitation for your virtual exam room appointment with our provider. This invitation contains your unique exam room identification number to protect your privacy with our provider.

The virtual exam room is in an application called BlueJeans. You will need to download and install the BlueJeans app on your smart phone, ipad, tablet, or computer with a web camera prior to your appointment date.

You can view an instructional video here:

- Android users: https://support.bluejeans.com/s/article/Video-Joining-a-meeting-from-the-Android-App
- Desktop users: https://support.bluejeans.com/s/article/Joining-a-meeting-from-your-computer
- iPhone and iPad users: https://support.bluejeans.com/s/article/iPhone-and-iPad-BlueJeans-app
- Web Browser: https://support.bluejeans.com/s/article/Video-Joining-a-Meeting-from-a-Browser

Or follow these easy steps:

1. Visit the BlueJeans for Android page on the Google Play Store, or search BlueJeans in the app store for Apple.
2. Select Install, and launch the App from your device to begin.
3. After launching the app, select “Join a meeting or Event”
4. Join meeting as a guest using the 9-digit meeting room ID you were provided in the email invitation on the day of your appointment.

At your appointment time:

- Guests can join meetings using the BlueJeans Mobile Apps without needing to sign in or create an account. Just join your session as a guest.
- It is OK to enter the room a few minutes early. Try to not be late.
- Please do not mute your microphone or camera. The icons should look like those pictured below:

- At the end of your call, simply click on the red telephone hang-up icon.
- If you have technical difficulties at the time of the appointment and you cannot connect with the provider, your visit will be converted to a telephone visit. You can expect a call from your provider to resume your conversation.

Please call our office at 502-588-2160 if you have any problems or if you need to reschedule your appointment.

Practice or provider must obtain verbal consent from patient for telemedicine/telephone treatment. It is recommended that the physician create a Cerner/Allscripts Macro to ensure proper verbiage.

This consent must be documented as such:

[Mr/Ms _] was located at [_] and I was located at [_] for this telemedicine/telephone encounter. We utilized _____[phone/software/product/app used] for the encounter and [Mr/Ms _] were able to hear [and see] each other simultaneously in real time. I introduced myself and verified [Mr/Ms _]'s identity. I explained how the telemedicine visit will occur. I advised [Mr/Ms _] that technology-related delays and breaches of privacy are potential risks associated with conducting the encounter via telemedicine.

I also advised [Mr/Ms _] that at any point [he/she] may terminate the telemedicine encounter and withdraw his/her consent for receiving care via telemedicine without affecting [his/her] ability to receive future care from us, and that I may also terminate the telemedicine encounter if I determine that an in-person visit is more appropriate for the condition[s] for which treatment is sought.

Having covered these considerations, [Mr/Ms __] verbally acknowledged them and gave consent for the use of telemedicine in [his/her] care.

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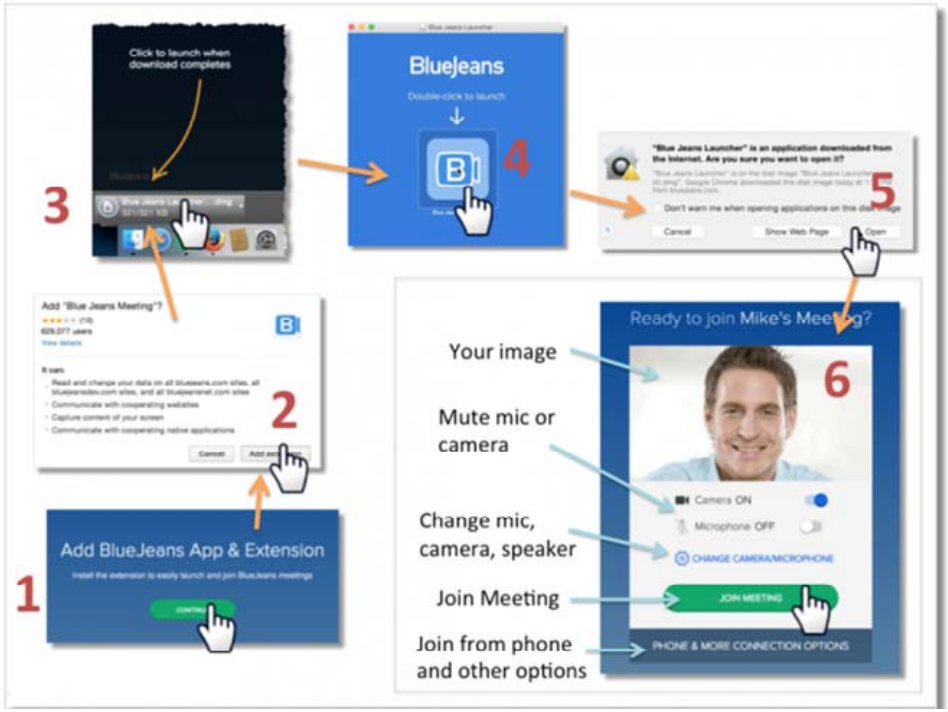
TELEHEALTH: HOW-TO GUIDES/ INSTRUCTIONS

MARCH 19 - JUNE 30, 2020

Installing BlueJeans on Office Computer

Go To BlueJeans Downloads Page → Start the installation → Add the extension → Click when download completes → Double-click to launch the app → Confirm to open the app

Make sure you're ready to join the meeting at this time → Watch 'How to Schedule' video → Schedule Patient Visits



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Quick Start: Scheduler Instructions for Creating Appointments in BlueJeans

To schedule a new meeting using the Web Scheduler, first log into your account from the website. Navigate to your Meetings page and click "Schedule Meeting" to create a new scheduled meeting.

Scheduling Walkthrough (refer to snapshots below):

1. Enter a **Title** for your new meeting.
2. Choose a **Start and End time** for your meeting. (Participants outside of the set time zone will have their invitation times adjusted to match their local time zone)
3. Enter the email addresses of the participants to invite to this meeting. The meeting invitation will be sent to these email addresses.
4. Click **Schedule meeting** to create your new meeting!

IMPORTANT:

USE TELEMEDICINE APPOINTMENT TYPES WHEN ADDING TO CLINIC SCHEDULE

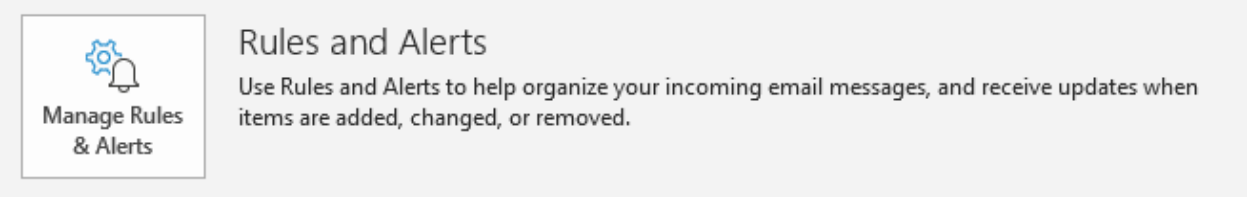
Blocking BlueJeans Appointments from Your Calendar

When you create a session in BlueJeans, it will send a meeting invite to the email address associated with your BlueJeans Account. This can be an annoyance and can clutter your calendar. The instructions below will show you how to set a rule to delete these invites automatically.

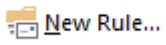
Note: the screen shots and steps below are from the ULP Outlook and OWA environment. Users of other email domains may see minor differences, but the process should be very similar.

For Outlook Client Users

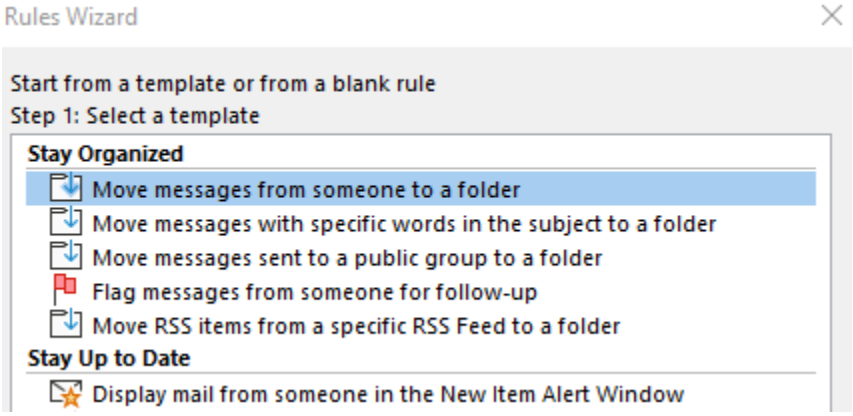
In Outlook, go to **File**, **Manage Rules and Alerts**



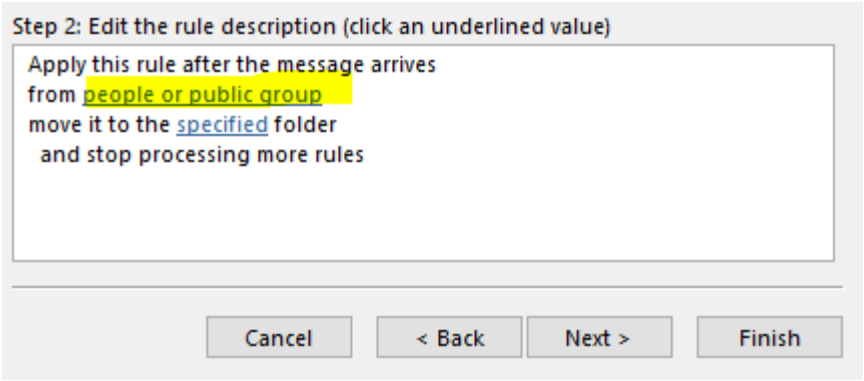
Click **New Rule**



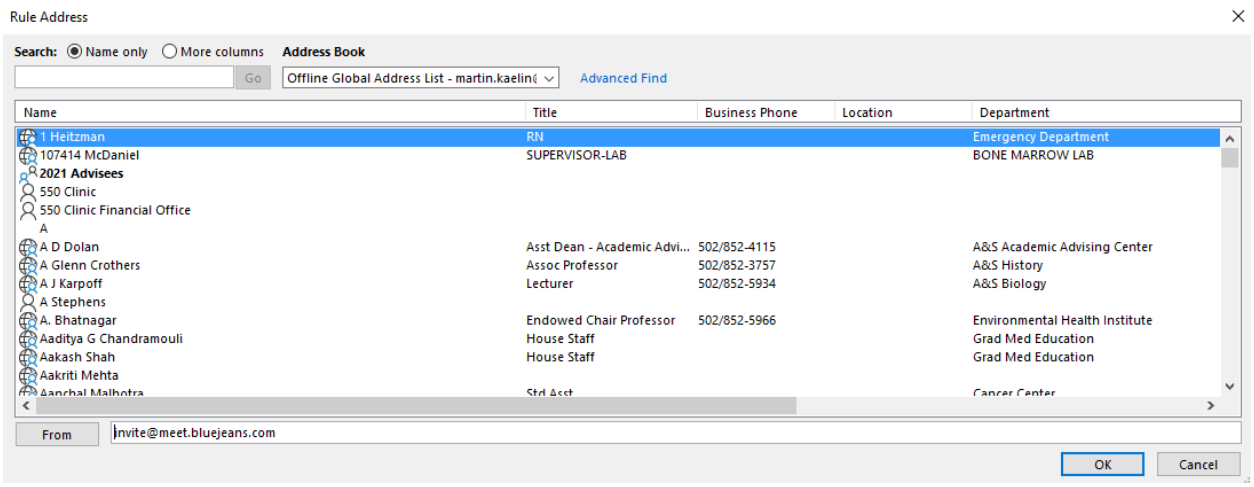
Select "**Move messaged form someone to a folder**" and click **next**



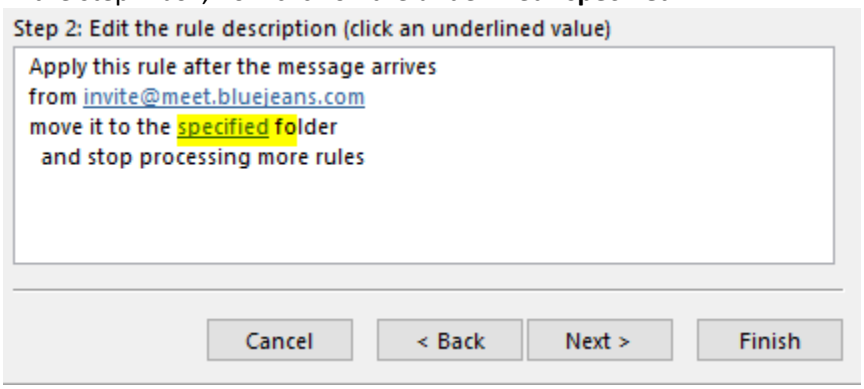
In the step 2 box, click on the underlined "**people or public group**"



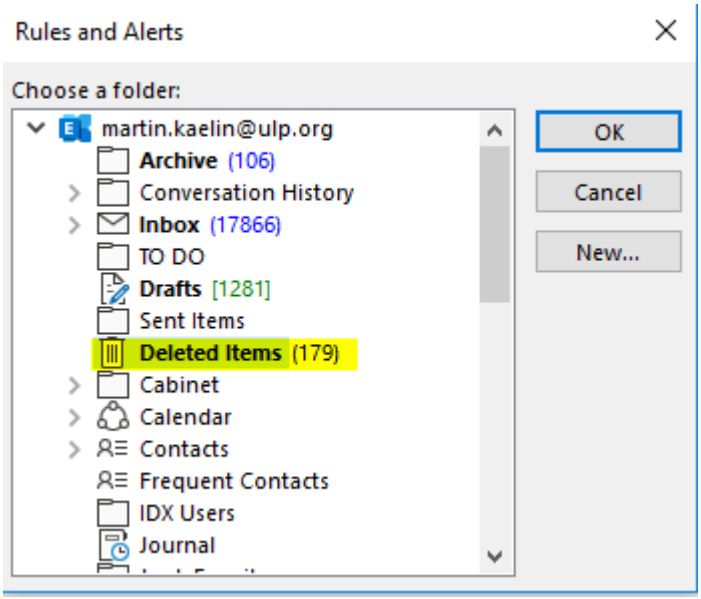
In the dialog box that pops up, paste the address **invite@meet.bluejeans.com** into the **FROM** field at the bottom and click **OK**:



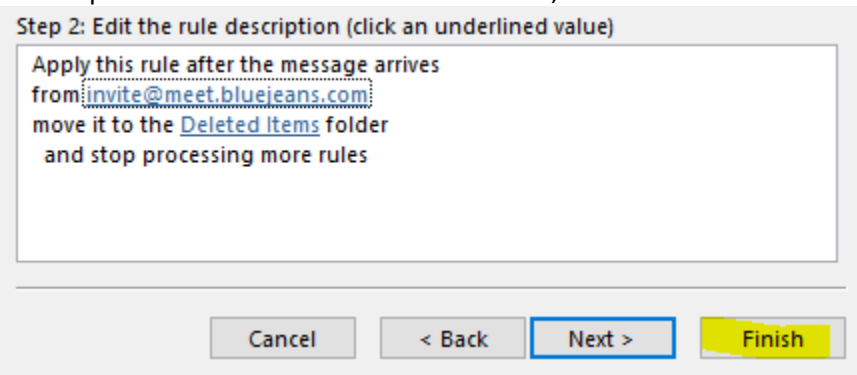
In the step 2 box, now click on the underlined "**specified**"



Select "**Deleted Items**" from the list of folders and click **OK**



The Step 2. Box should now look like this. If so, click Finish on the Rules Wizard window.



Click **OK** on the Rules and Alerts dialog box.

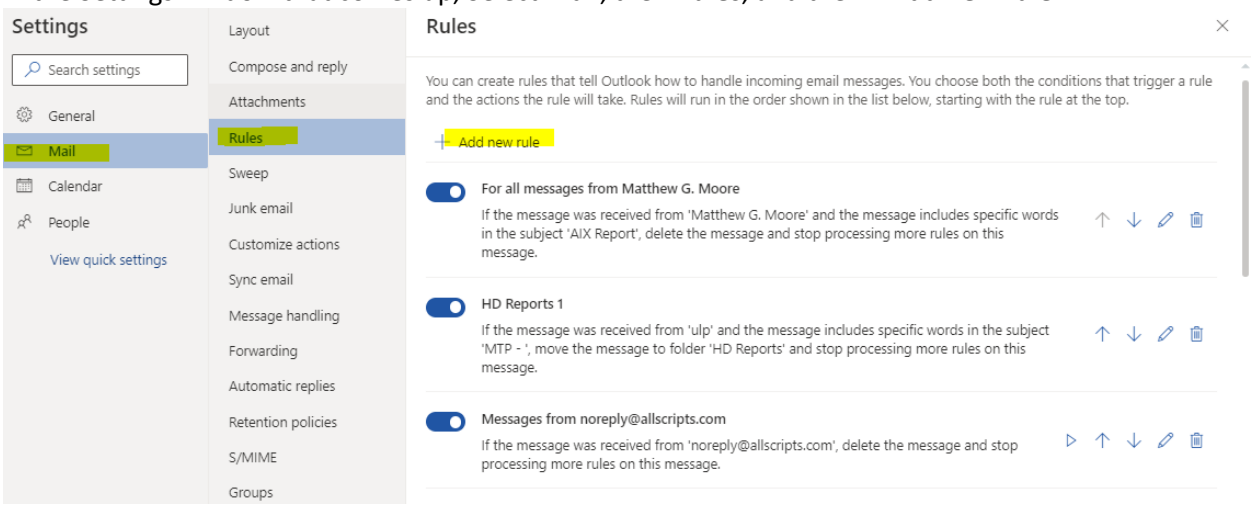
Your rule should now be in place and invites from Blue Jeans should be automatically deleted.

For Outlook OWA (Online Web Access) Users

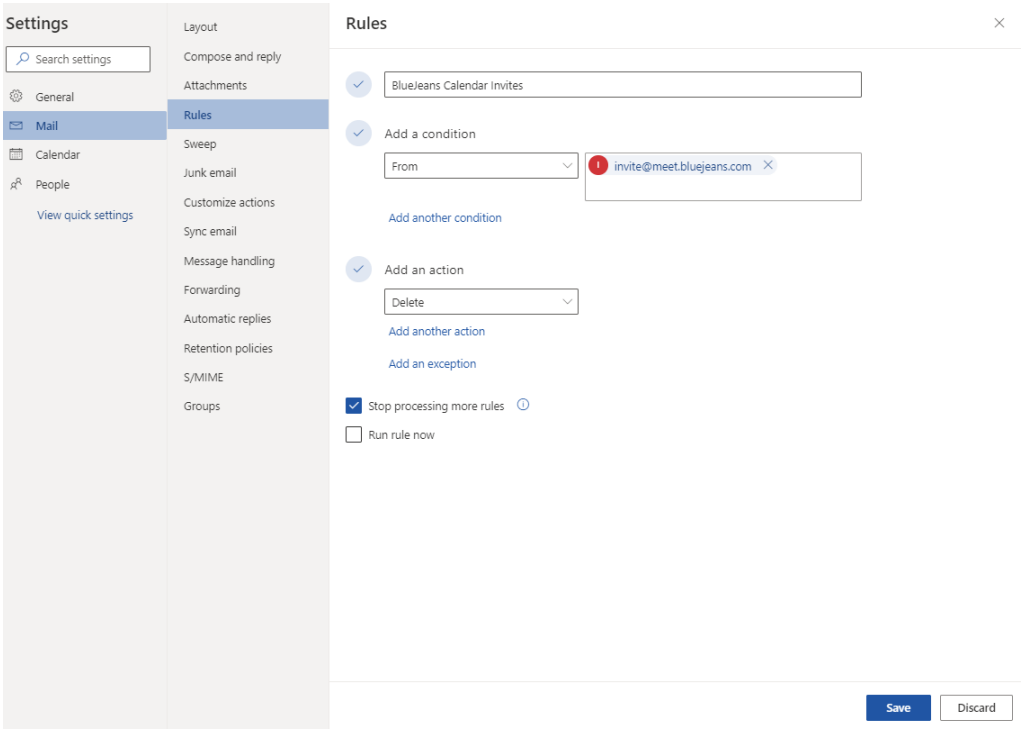
Click on the settings gear icon in the upper right-hand corner of the window.

Click on "**View all Outlook Settings**" at the bottom of the Settings window.

In the Settings window that comes up, Select **Mail**, then **Rules**, and then **+ Add new rule**



A new dialog will pop up. In the first line, give the Rule a name that makes sense to you.
In the Condition, select "**From**" and enter **invite@meet.bluejeans.com** in the second field.
Under Add an action, select Delete. Your Rule should look like this, of so, click **Save**.



You can now click the **X** in the upper right-hand corner. Your rule should now be in place and invites from Blue Jeans should be automatically deleted.

UL Health | Telehealth

Revised 4/5/20

Patient Instructions

(Specific information may vary by practice. You will need to update to ensure it is true to your practice.)

On the morning of the appointment our office staff will call you to verify insurance information and collect any required copayment or coinsurance. You will then be transferred to one of our Nurses or Medical Assistants to review your medications, health history, and our consent for a telehealth visit. At the completion of the call you will be sent a meeting invitation for your virtual exam room appointment with our provider. This invitation contains your unique exam room identification number to protect your privacy with our provider.

The virtual exam room is in an application called BlueJeans. You will need to download and install the BlueJeans app on your smart phone, ipad, tablet, or computer with a web camera prior to your appointment date.

You can view an instructional video here:

- Android users: https://support.bluejeans.com/s/article/Video-Joining-a-meeting-from-the-Android-App
- Desktop users: https://support.bluejeans.com/s/article/Joining-a-meeting-from-your-computer
- iPhone and iPad users: https://support.bluejeans.com/s/article/iPhone-and-iPad-BlueJeans-app
- Web Browser: https://support.bluejeans.com/s/article/Video-Joining-a-Meeting-from-a-Browser

Or follow these easy steps:

1. Visit the BlueJeans for Android page on the Google Play Store, or search BlueJeans in the app store for Apple.
2. Select Install, and launch the App from your device to begin.
3. After launching the app, select “Join a meeting or Event”
4. Join meeting as a guest using the 9-digit meeting room ID you were provided in the email invitation on the day of your appointment.

At your appointment time:

- Click on the BlueJeans link emailed from the office. Guests can join meetings using the BlueJeans Mobile Apps without needing to sign in or create an account. Just join your session as a guest.
- It is OK to enter the room a few minutes early. Please do not be late.
- Please do not mute your microphone or camera. The icons should look like those pictured below:

- At the end of your call, simply click on the red telephone hang-up icon.

- If you have technical difficulties at the time of the appointment and you cannot connect with the provider, your visit will be converted to a telephone visit. You can expect a call from your provider to resume your conversation.

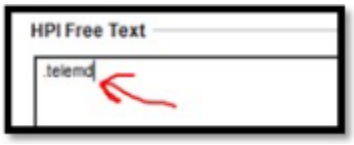
Please call our office at (502) 588-XXXX if you have any problems or if you need to reschedule your appointment.

MARCH 19 - JUNE 30, 2020

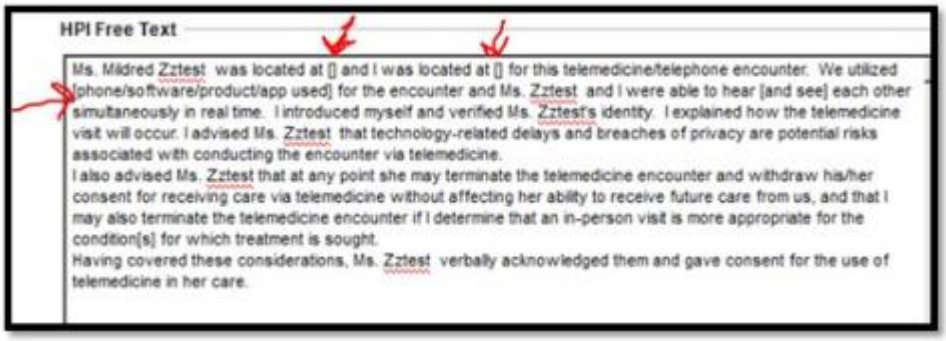
To Create Telemed Consent Macro in Allscripts

To ensure documentation of Telemedicine consent received, create macro in allscripts by following the steps below.

1. In an empty text box in Allscripts, enter **.telemed**



2. Click 'enter' (on the keyboard) and the message renders.
3. The provider must then fill in the blanks and correct the multiple choices.



UofL Health | Telehealth

TELEHEALTH: FORMS

MARCH 19 - JUNE 30, 2020

Telehealth Project Initiation (rev. 4/6/20)

Department:	**AMG / CMG** **Scheduling Dept (Centricity):**
Provider(s): **(please list residents separately)**	**Project Includes: Inpatient Care / Outpatient Care**
	Scheduling Location:
	Initiation Date:
	Practice Manager: **Phone:** **Email:**
Email this form to telehealth@ulp.org	**IT Hardware Needs (laptop, webcam, headphones):**

FOR INTERNAL USE:

Legal Review Required: YES / NO
Comments:

Task Force Administrator Responsibilities:
- ❑ Send to atosupport@louisville.edu to request BlueJeans license(s)
- ❑ Distribute to Telehealth Task Force

Operations Responsibilities:
- ❑ Inform Access Contact of New Telehealth Project

ULP Practice Manager Responsibilities:
- ❑ Ensure BlueJeans Scheduling Process for Provider(s)
- ❑ Ensure Schedulers Use **Telemedicine Appointment Types**
- ❑ Ensure Insurance Authorization, Consent and CoPay (copay waived if related to possible COVID19)
- ❑ Ensure Telehealth Notes Are Completed Within 48 hours of Encounter

IT Responsibilities:
- ❑ Add Telemedicine Appointment Types T30/T60
- ❑ Add Location 02 to Provider Profile
- ❑ Ensure Hardware Functionality
- ❑ Install BlueJeans or Ensure Web Application Access/Functionality

MAR 19 – JUN 30, 2020

UL Health | Telehealth

TELEHEALTH: CODING & BILLING

MARCH 19 - JUNE 30, 2020

New Patient – Office or Other outpatient – **Requires 3 of 3 components be met/exceeded**			
99201	· Problem focused history · Problem focused exam · Straightforward medical decision making · Typically, 10 minutes face-to-face with patient and/or family	**99204**	· Comprehensive history · Comprehensive exam · Moderate complexity medical decision making · Typically, 45 minutes face-to-face with patient and/or family
99202	· Expanded problem focused history · Expanded problem focused exam · Straightforward medical decision making · Typically, 20 minutes face-to-face with patient and/or family	**99205**	· Comprehensive history · Comprehensive exam · High complexity medical decision making · Typically, 60 minutes face-to-face with patient and/or family
99203	· Detailed history · Detailed exam · Low complexity medical decision making · Typically, 30 minutes face-to-face with patient and/or family		
Established Patient – Office or Other outpatient – **Requires 2 of 3 components be met/exceeded**			
99211	· May not require the presence of a physician or other qualified health care professional · Typically, 5 minutes performing or supervising these services	**99214**	· Detailed history · Detailed exam · Moderate complexity medical decision making · Typically, 25 minutes spent face-to-face with patient and/or family
99212	· Problem focused history · Problem focused exam · Straightforward medical decision making · Typically, 10 minutes face-to-face with patient and/or family	**99215**	· Comprehensive history · Comprehensive exam · Moderate complexity medical decision making · Typically, 40 minutes face-to-face with patient and/or family
99213	· Expanded problem focused history · Expanded problem focused exam · Low complexity medical decision making · Typically, 15 minutes face-to-face with patient and/or family		
Consults – Office or other outpatient – **Requires 3 of 3 components be met/exceeded**			
99241	· Problem focused history · Problem focused exam · Straightforward medical decision making · Typically, 15 minutes face-to-face with patient and/or family	**99244**	· Comprehensive history · Comprehensive exam · Moderate complexity medical decision making · Typically, 60 minutes face-to-face with patient and/or family
99242	· Expanded problem focused history · Expanded problem focused exam · Straightforward medical decision making · Typically, 30 minutes face-to-face with patient and/or family	**99245**	· Comprehensive history · Comprehensive exam · High complexity medical decision making · Typically, 80 minutes face-to-face with patient and/or family
99243	· Detailed history · Detailed exam · Low complexity medical decision making · Typically, 40 minutes face-to-face with patient and/or family		

Codes for Behavioral Change Interventions			
99406	Smoking cessation 3-10 minutes	**G0396**	Alcohol/Substance abuse 15 - 30 minutes
99407	Smoking cessation greater than 10 minutes	**G0397**	alcohol/Substance abuse greater than 30 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening – 15 to 30 minutes	**G0436**	On list but no longer a valid code as of 2015
G2086	Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month	**G0437**	On list but no longer a valid code as of 2015
G2087	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month	**G0442**	Annual alcohol misuse screening, 15 minutes

G2088	Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)	G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
Virtual Check In Services			
G2012	Telephone - typically 5 -10 minutes	G2010	Captured video or image
Telephone Services			
99441	5 - 10 minutes - time must be documented	99443	21 - 30 minutes - time must be documented
99442	11 - 20 minutes - time must be documented		
On-line Digital Evaluations			
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes	99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11– 20 minutes		
Annual Wellness Exams			
G0438	Annual wellness visit, includes personalized prevention of service (PPPS), first visit	G0439	Annual wellness visit, includes a personalized prevention plan of service (PPPS) subsequent visit
Telehealth Consultations, Emergency Department or Inital Patient			
G0425	Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth	G0427	Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth
G0426	Telehealth consultation, emergency department or initial inpatient, typically 50 minutes communicating with the patient via telehealth		
Follow-up Inpatient Telehealth Consultations Furnished to Beneficiaries in hospitals			
G0406	Follow-up inpatient consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth	G0408	Follow-up inpatient consultation, complex, physicians typically spend 35 minutes communicating with the patient via telehealth
G0407	Follow-up inpatient consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth		
Subsequent Hospital Care Services, with the limitation of 1 Telehealth Visit EVERY 3 DAYS			
99231	· Problem focused interval history · Problem focused exam · Straightforward or low complexity medical decision making · Typically, 15 minutes at bedside and on patient's hospital floor/unit	99233	· Detailed interval history · Detailed exam · High complexity medical decision making · Typically, 35 minutes at bedside and on patient's hospital floor/unit
99232	· Expanded problem focused interval history · Expanded problem focused exam · Moderate complexity medical decision making · Typically, 25 minutes at bedside and on patient's hospital floor/unit		
Subsequent Nursing Facility Care			
99307	A problem focused interval history;Problem focused exam; straightforward MDM; Typically 10 minutes	99309	Detailed hisptory, detailed exam, moderate MDM; 25 minutes
99308	EPF history, EPF exam, low MDM; 15 minutes	99310	Comprehensive history, comprehensive exam, high MDM; 35 minutes
Individual and group kidney disease education services			
G0420	Face-to-face educational services related to the care of chronic kidney disease; individual, per session, per one hour	G0421	Face-to-face educational services related to the care of chronic kidney disease; group, per session, per one hour
Individual and Group Diabetes Self-Management Training Services with a Minimum of 1 Hour of in-person instruction furnished in the initial year training period to ensure effective injection training			
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes
Individual Psychotherapy - Time MUST be Documented			
90832	Psychotherapy, 30 minutes with patient	90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)

90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)	90837	Psychotherapy, 60 minutes with patient
90834	Psychotherapy, 45 minutes with patient	90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
Telehealth Pharmacology Management			
G0459	Inpatient telehealth pharmacologic management, including prescription, use, and review of medication with no more than minimal medical psychotherapy		
Psychiatric Diagnostic Interview Examination			
90791	Psychiatric diagnostic evaluation	90792	Psychiatric diagnostic evaluation with medical services
Individual and Group Medical Nutrition Therapy			
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	97804	Medical nutrition therapy; group (2 or more individual(s)), each 30 minutes
Health Risk Assessment			
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument	G0444	Annual Depression Screening
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument	G0445	High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education,skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes
99495	Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge)	G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
99496	Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge)	G0447	Face-to-face behavioral counseling for obesity, 15 minutes
99447	Advanced care planning, 30 minutes	G0506	Comprehensive assessment of and care planning for patients requiring chronic care management
99498	Advanced care planning, additional 30 minutes	G0508	Telehealth consultation, Critical Care, initial, physicians typically spend 60 minutes communicating with the patient and providers via telehealth
		G0509	Telehealth consultation, Critical Care, subsequent, physicians typically spend 50 minutes communicating with the patient and providers via telehealth
Psychotherapy for Crisis			
90785	Interactive Complexity Psychiatry Services and Procedures	90847	A problem focused interval history;Problem focused exam; straightforward MDM; Typically 10 minutes
90839	Psychotherapy for crisis; first 60 minutes	99354	Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)	99355	Each additional 30 minutes
90845	Psychoanalysis	99356	Prolonged service in the inpatient or observation setting requiring unit/floor time beyond the usual service, first hour
90846	Family psychotherapy (conjoint psychotherapy)(without patient present)	99357	Each additional 30 minutes
Prolonged Preventative Services			
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour	G0513	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)

96150	On list but no longer a valid code as of 2019	**G0514**	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service)
96151	On list but no longer a valid code as of 2019	**96154**	On list but no longer a valid code as of 2019
96152	On list but no longer a valid code as of 2019	**96160**	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96153	On list but no longer a valid code as of 2019	**96161**	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument

EXAM Elements

Constitutional	General Appearance of patient
ENT	External Ears & nose
	Lips teeth & gums
	Eyes
Respiratory	Respiratory Effort
Musculosketetal	Gait & Station
Skin	Inspection of skin
Psych	Judgement & Insight
	Orientation to time, place & person
	Memory
	Mood & Effect
**	**During Emergency situations (as with COVID-19) it would be recommended for new patients that providers bill on time component and state that greater than 50% of the time was spent counseling the patient.**

ESRD	
Included in Monthly Captiation	
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
ESRD for home dialysis per full month	
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
ESRD for home dialysis less full month	
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older

LIST OF MEDICARE TELEHEALTH SERVICES CY 2020	
Code	**Short Descriptor**
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90839	Psytx crisis initial 60 min
90840	Psytx crisis ea addl 30 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90951	Esrd serv 4 visits p mo <2yr
90952	Esrd serv 2-3 vsts p mo <2yr
90954	Esrd serv 4 vsts p mo 2-11
90955	Esrd srv 2-3 vsts p mo 2-11
90957	Esrd srv 4 vsts p mo 12-19
90958	Esrd srv 2-3 vsts p mo 12-19
90960	Esrd srv 4 visits p mo 20+
90961	Esrd srv 2-3 vsts p mo 20+
90963	Esrd home pt serv p mo <2yrs
90964	Esrd home pt serv p mo 2-11
90965	Esrd home pt serv p mo 12-19
90966	Esrd home pt serv p mo 20+
90967	Esrd home pt serv p day <2
90968	Esrd home pt serv p day 2-11
90969	Esrd home pt serv p day 12-19
90970	Esrd home pt serv p day 20+
96116	Neurobehavioral status exam
96150	Assess hlth/behave init
96151	Assess hlth/behave subseq
96152	Intervene hlth/behave indiv
96153	Intervene hlth/behave group
96154	Interv hlth/behav fam w/pt
96160	Pt-focused hlth risk assmt
96161	Caregiver health risk assmt
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est

LIST OF MEDICARE TELEHEALTH SERVICES CY 2019	
Code	**Short Descriptor**
90785	Psytx complex interactive
90791	Psych diagnostic evaluation
90792	Psych diag eval w/med srvcs
90832	Psytx pt&/family 30 minutes
90833	Psytx pt&/fam w/e&m 30 min
90834	Psytx pt&/family 45 minutes
90836	Psytx pt&/fam w/e&m 45 min
90837	Psytx pt&/family 60 minutes
90838	Psytx pt&/fam w/e&m 60 min
90839	Psytx crisis initial 60 min
90840	Psytx crisis ea addl 30 min
90845	Psychoanalysis
90846	Family psytx w/o patient
90847	Family psytx w/patient
90951	Esrd serv 4 visits p mo <2yr
90952	Esrd serv 2-3 vsts p mo <2yr
90954	Esrd serv 4 vsts p mo 2-11
90955	Esrd srv 2-3 vsts p mo 2-11
90957	Esrd srv 4 vsts p mo 12-19
90958	Esrd srv 2-3 vsts p mo 12-19
90960	Esrd srv 4 visits p mo 20+
90961	Esrd srv 2-3 vsts p mo 20+
90963	Esrd home pt serv p mo <2yrs
90964	Esrd home pt serv p mo 2-11
90965	Esrd home pt serv p mo 12-19
90966	Esrd home pt serv p mo 20+
90967	Esrd home pt serv p day <2
90968	Esrd home pt serv p day 2-11
90969	Esrd home pt serv p day 12-19
90970	Esrd home pt serv p day 20+
96116	Neurobehavioral status exam
96150	Assess hlth/behave init
96151	Assess hlth/behave subseq
96152	Intervene hlth/behave indiv
96153	Intervene hlth/behave group
96154	Interv hlth/behav fam w/pt
96160	Pt-focused hlth risk assmt
96161	Caregiver health risk assmt
97802	Medical nutrition indiv in
97803	Med nutrition indiv subseq
97804	Medical nutrition group
99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est

99215	Office/outpatient visit est
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99354	Prolonged service office
99355	Prolonged service office
99356	Prolonged service inpatient
99357	Prolonged service inpatient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min
99498	Advncd are plan addl 30 min
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0270	Mnt subs tx for change dx
G0296	Visit to determ ldct elig
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G0406	Inpt/tele follow up 15
G0407	Inpt/tele follow up 25
G0408	Inpt/tele follow up 35
G0420	Ed svc ckd ind per session
G0421	Ed svc ckd grp per session
G0425	Inpt/ed teleconsult30
G0426	Inpt/ed teleconsult50
G0427	Inpt/ed teleconsult70
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel>10min
G0438	Ppps, initial visit
G0439	Ppps, subseq visit
G0442	Annual alcohol screen 15 min
G0443	Brief alcohol misuse counsel
G0444	Depression screen annual
G0445	High inten beh couns std 30m
G0446	Intens behave ther cardio dx
G0447	Behavior counsel obesity 15m
G0459	Telehealth inpt pharm mgmt
G0506	Comp asses care plan ccm svc
G0508	Crit care telehea consult 60
G0509	Crit care telehea consult 50
G0513	Prolong prev svcs, first 30m
G0514	Prolong prev svcs, addl 30m
G2086	Off base opioid tx first m
G2087	Off base opioid tx, sub m
G2088	Off opioid tx month add 30

99215	Office/outpatient visit est
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care
99307	Nursing fac care subseq
99308	Nursing fac care subseq
99309	Nursing fac care subseq
99310	Nursing fac care subseq
99354	Prolonged service office
99355	Prolonged service office
99356	Prolonged service inpatient
99357	Prolonged service inpatient
99406	Behav chng smoking 3-10 min
99407	Behav chng smoking > 10 min
99495	Trans care mgmt 14 day disch
99496	Trans care mgmt 7 day disch
99497	Advncd care plan 30 min
99498	Advncd are plan addl 30 min
G0108	Diab manage trn per indiv
G0109	Diab manage trn ind/group
G0270	Mnt subs tx for change dx
G0296	Visit to determ ldct elig
G0396	Alcohol/subs interv 15-30mn
G0397	Alcohol/subs interv >30 min
G0406	Inpt/tele follow up 15
G0407	Inpt/tele follow up 25
G0408	Inpt/tele follow up 35
G0420	Ed svc ckd ind per session
G0421	Ed svc ckd grp per session
G0425	Inpt/ed teleconsult30
G0426	Inpt/ed teleconsult50
G0427	Inpt/ed teleconsult70
G0436	Tobacco-use counsel 3-10 min
G0437	Tobacco-use counsel>10min
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April 1, 2020

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Medicare and Medicaid Programs: Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency (CMS-1744-IFC)

Under the March 31, 2020 Interim Final Rule with Comment Period additional waivers were implemented by CMS. Payments can begin under these changes as of March 1, 2020. The comment period ends June 1, 2020.

Key provisions of the rule are below. Additional information can be found in the rule, available at:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-06990.pdf or in the CMS Fact Sheet.

Telehealth
CMS expanded payment for Medicare office, hospital, and other visits furnished via telehealth across the country. Payment will be made for professional services furnished to beneficiaries in all settings, including the patient's home.

- Payment for services delivered via telehealth are the same as if those services were delivered in person.
- While Medicare coinsurance and deductibles would generally apply for these services, HHS OIG is providing flexibility for providers to waive or reduce cost sharing for telehealth visits paid by federal programs.
- The telehealth services may be provided for new and established patients.
- HHS Office for Civil Rights (OCR) will not impose penalties for HIPAA noncompliance violations against health care providers make good faith provision of telehealth services.
- Allows the use of cell phones that have video capability for telehealth services.

Under the provisions of the interim final rule, CMS establishes the following additional expansions related to telehealth services and payment.

- Practitioners can render telehealth services from their home without reporting their home address on their Medicare enrollment.
- Providers should note the place of services for services delivered via telehealth as if those services had been provided in person. The payment rate will be assigned at the rate that ordinarily would have been paid under the Physician Fee Schedule were the services had been furnished in-person. Providers should append the -95 modifier to these claims.
- In addition to the current list of covered telehealth services, clinicians can now provide the following additional services by telehealth:
    - Emergency department visits, levels 1-5
    - Initial and subsequent observation and observation discharge day management
    - Initial hospital care and hospital discharge day management

    - Initial nursing facility visits, all levels, and nursing facility discharge day management
    - Critical care services
    - Domiciliary, rest home, or custodial care services, new and established patients
    - Home visits, new and established patients, all levels
    - Inpatient neonatal and pediatric critical care, initial and subsequent
    - Initial and continuing intensive care services
    - Care planning for patients with cognitive impairment
    - Physical and occupational therapy, all levels, speech-language therapy
    - Radiation treatment management services
- Clinicians can provide virtual check-in services (HCPCS codes G2010, G2012) to both new and established patients. Virtual check-in services were previously limited to established patients.
- Licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).
- A broad range of clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966 -98968; 99441-99443)
- Certain services no longer have frequency limitations related to telehealth.
- Clinicians can provide remote patient monitoring services to both new and established patients. These services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.
- For Medicare patients with End Stage Renal Disease (ESRD), clinicians no longer must have one "hands on" visit per month for the current required clinical examination of the vascular access site.

Teaching Physician Rules

- Requirement of physical presence of the teaching physician during the key or critical part of the service can be met through direct supervision through virtual means, i.e., real time audio and video communication that allows the teaching physician to interact with the resident
- Teaching physicians will be able to bill for the following services of residents provided that the resident is under the direct supervision of the teaching physician through virtual means:
    - All levels of evaluation and management services under the primary care exception (PCE) provided in primary care centers
    - Interpretation of diagnostic radiology and other diagnostic tests. The teaching physician must review the resident's interpretation.
    - Psychiatry services
- These exceptions do not apply in the case of surgical, high risk, interventional, or other complex procedures, services performed through an endoscope, and anesthesia services. CMS asks for comments on this.
- If a resident is under quarantine but is otherwise able to furnish services that do not require face-to-face patient care, such as reading results of tests and imaging studies,

Medicare will allow billing for teaching physician services if the resident is under direct supervision via virtual means.
- Moonlighting residents will be able to bill provided that the resident is fully licensed to practice and the services are not performed as part of the approved GME program. This provision is mostly applicable to fellows.

Counting Resident Time for DGME and IME
- Hospitals can claim a resident for IME and DGME if the hospital pays the resident's salary and fringe for the time a resident is at home or in the home of a patient who already is the patient of the physician or hospital and performs services within the scope of the approved residency program.

Impact of COVID-19 on Part C and Part D Quality Star Ratings
- Amends the calculations of the 2021 and 2022 Part C and D Star Ratings to incorporate changes to address the expected impact of the pandemic on data collection (e.g., Healthcare Effectiveness Data and Information Set [HEDIS] and Consumer Assessment of Healthcare Providers and Systems [CAHPS] data) and performance. To that end, the rule details how the ratings will be calculated for 2021 and 2022 to ensure that there is no diversion from handling day-to-day care during the emergency to meet data collection needs and that actual performance in 2020 during the emergency period does not negatively impact 2022 ratings.

Medicare Shared Savings Program (SSP) ACOs
- Revises SSP's extreme and uncontrollable circumstances policy to extend protection to ACOs that may not be able to completely and accurately report quality data for 2019 (despite the extended deadline to report).
- Clarifies that the policy in regard to adjusting the amount of shared losses an ACO owes would not apply to the 2019 performance year, because the extreme and uncontrollable circumstance did not occur in 2019. That policy will apply for 2020 performance year reconciliation.

Innovation Center Models
- *Comprehensive Care for Joint Replacement (CJR) Model*: Expands the model's extreme and uncontrollable circumstances policy to include the pandemic, which will apply to all hospitals in the model; episodes that initiated within 30 days prior to the declared state of emergency or during the state of emergency will have their actual episode expenditures capped at the target amount. Additionally, CMS will extend the fifth model year by 3 months, through March 31, 2021.

Subsequent Care and Critical Care Services in Inpatient Settings
- Removes frequency restriction for the provision of subsequent inpatient services through Medicare telehealth services (CPT Codes 99231 through 99233). Previously, the provision of these subsequent services furnished through telehealth was limited to once every 3 days.

- Removes restriction that critical care consultation codes (HCPCS codes G0508 and G0509) may only be furnished to a Medicare beneficiary once per day.

Inpatient Hospital Services Furnished Under Arrangements outside the Hospital

- Amends "under arrangements" policy so that when routine services are provided "under arrangements" outside the hospital to its inpatients, these services are considered as being provided by the hospital. Services provided to patients outside the hospital are considered as being provided "under arrangement" (rather than by the hospital). Ordinarily, Medicare will only pay for nursing and related services, use of hospital facilities, and medical social services as inpatient hospital services when they are considered routine services provided in the inpatient setting.

MIPS

- Modifies the MIPS Extreme and Uncontrollable Circumstances policy to allow clinicians who have been adversely affected by COVID1-9 to submit an application and request reweighting of the MIPS performance categories for the 2019 performance year.

Stark Law Waivers

- CMS will permit certain physician referrals for certain health care services payable by the Medicare that would otherwise violate the Stark Law. CMS provides a list of examples, which include hospitals paying above or below fair market value to rent equipment or receive services from physicians (or vice versa); hospitals providing benefits to medical staffs, such as daily meals, laundry service, child care services; and others.

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April 1, 2020

Provider FAQs

This document has been updated to address telehealth and MCO-related FAQs that have been received. The MCO FAQs begin on page 12 of this document.

Pursuant to 907 KAR Chapter 17 and the DMS – MCO contracts, DMS has directed the contracted MCOs to comply with and implement these FAQs.

Provider Telehealth FAQs:

The March 17, 2020 Behavioral Health Provider letter addressed multiple medical and behavioral health issues relating to telehealth. In addition, future executive orders and administrative regulations to expand telehealth services are expected. As additional guidance, DMS is offering this FAQ document for providers and recipients.

1. What behavioral health services are now allowable via telehealth that were not before?

Within 907 KAR Chapter 15, these services are restricted to face-to-face only. However, for the duration of this declared emergency, the following services are permissible as synchronous telehealth or as a telecommunication mediated health service:

- Peer support services
- Intensive outpatient program services
- Group outpatient therapy
- Service planning
- Partial hospitalization
- Targeted case management
- Mobile crisis services
- Applied Behavioral Analysis
- Comprehensive Community Support Services
- Therapeutic Rehabilitation Program

2. What services are now available via telehealth or via a telehealth-like service throughout the entire Medicaid program?

DMS is making system changes to allow for all provider types to bill for telehealth services. To the extent possible,

providers should provide all services via telehealth. If a service could have been provided via telehealth, but the individual or provider does not have the capability to deliver or participate in the service via telehealth, the service may be delivered via telephone as a "telecommunication or other electronically mediated health service". If service delivery is audio-only but the service would normally be dependent on the exchange of visual information, the provider should facilitate appropriate electronic or other data exchanges to support any treatment delivered.

3. How should I comply with HIPAA in delivering telehealth?

For the duration of this current COVID-19 nationwide public health emergency, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) has relaxed its enforcement of HIPAA for certain non-public facing applications. This means that OCR will not enforce penalties for the *good faith provision* of telehealth. Specifically included popular applications that are *currently exempted* include, but are not limited to, these services:

- Apple FaceTime
- Facebook Messenger video chat
- Google Hangouts video
- Skype

For current or future reference, these services advertise as being currently HIPAA-compliant video communication (providers may need to conduct additional verification with these services). DMS and CHFS are not endorsing any of these products and only include them for informational purposes:

- Skype for Business
- Zoom for Healthcare
- BlueJeans
- Vidyo
- VSee
- Doxy.me
- thera-Link
- Updox
- Google G Suite Hangouts Meet

Public facing services are specifically not allowed by OCR and should *not* be used for the provision of telehealth. These include, but are not limited to:

- Facebook Live
- Twitch
- TikTok

You may wish to further review this communication from the OCR here: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

4. (UPDATED) How can I utilize the telephone or other audio-only technology during this emergency?

DMS has filed an emergency regulation to allow for "telecommunication or other electronically mediated health services" to be used throughout the Medicaid program. DMS envisions that these services will be utilized as a "telehealth-like" service wherever appropriate.

If they are real-time conversations, telephonic services - where it is not appropriate or possible for a visual video connection to be utilized - will be treated as synchronous telehealth. For further information about Medicare G codes, please see FAQs #8 and #47 below.

If a service could have been provided via telehealth, but the individual or provider does not have the capability to deliver or participate in the service via telehealth, the service may be delivered via telephone as a "telecommunication or other electronically mediated health service". If service delivery is audio-only but the service would normally be

dependent on the exchange of visual information, the provider should facilitate appropriate electronic or other data exchanges to support any treatment delivered.

5. Can some telehealth services be delivered by behavioral health associates under the supervision of a licensed behavioral health provider?

Yes. This will also be dependent on if the licensure board allows the practice or if the licensure board is overruled by an executive order. DMS will construe any emergency order, and the March 17 Behavioral Health letter as broadly as possible in allowing for telehealth to be provided by all behavioral health and medical providers.

6. (UPDATED CONTACT INFO) Will payers be required to honor all telehealth or telecommunication codes and modifiers?

Yes. The Medicaid MCOs will be expected to follow Medicaid policy during the state and national health emergency. Providers should report problems to ProviderMCOInquiry@ky.gov if MCOs are not complying with this direction. In addition, this form can be utilized: https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Documents/DMSFillableComplaintFormUpdate2017.pdf

7. Are BHSOs and CMHCs included in the March 17 Behavioral Health Provider letter?

This phrase from the notification modifies all current Chapter 15 Behavioral Health telehealth restrictions: "Therefore, licensed behavioral health providers can deliver services via telehealth, with the exception of residential substance use disorder treatment services and residential crisis services."

The department is interpreting this letter to include the CMHC itself as a licensed behavioral health provider that can – through its licensed behavioral health providers or provider equivalents – perform any behavioral health service via telehealth, with the exception of the letter's limitation of residential SUD or RCSU services.

The department is assuming that BHSOs and CMHCs are hiring and utilizing licensed behavioral health providers to the extent possible.

8. (UPDATED) How should the G2012 and G2010 Services be used in relation to the ability to provide a telehealth or telecommunication service with a place of service modifier?

DMS recommends utilizing the description within the G2012 and G2010 service when providing that service. If the health service being provided is more expansive than the definition in the G2012 or G2010 code, then DMS recommends still providing the service via synchronous telehealth or via a telecommunications or electronically mediated health service but noting how that service was delivered.

DMS expects that the G code rate will reimburse less than the appropriate service code rate, and would recommend using the appropriate service code with place of service modifier instead of the G code in most circumstances.

The G codes are limited in relation to the more expanded "telehealth-like" service option that DMS is utilizing for the duration of this emergency.

These codes (G2010 and G2012) are typically limited to MDs, APRNs, and DOs or other providers who code for evaluation and management codes. DMS is reimbursing these codes the same as Medicare.

DMS, however, has attempted to go beyond the G codes in allowing the use of telephones or audio-only internet connections. DMS has done this by suspending our own documentation and service requirements in Title 907 KAR via creation of the "telecommunication or electronically mediated health service" in 907 KAR 3:300. DMS is referring to this service as a "telehealth-like service". In lieu of the G codes, a "telehealth-like" service should be used when a video conference or more traditional telehealth service couldn't be used due to provider or recipient Internet access or ability. These "telehealth-like" services should be billed as if they were the regular service, but with the telehealth POS of 02. If this is done, the provider should not also bill for the G code, because there is no additional reimbursement.

9. Can DocuSign or similar programs be used to get e-signatures or consent releases for telehealth services?

Yes. DMS will accept electronic signatures for all purposes, and will require MCOs to comply.

10. My licensing board allows *more* telehealth than currently allowed via DMS administrative regulation, how should I proceed?

The department will construe any administrative regulations, executive orders, and provider letters as broadly as possible to allow for the most telehealth to be delivered as safely as possible to our members.

11. (UPDATED CONTACT INFO) An MCO or several MCOs will not allow a covered service for telehealth that is currently allowable via telehealth, how should I proceed?

DMS is requiring all Medicaid MCOs to cover all current services that are covered via telehealth during this time. In addition, DMS will require the MCOs to cover all services that are determined to be allowable via telehealth during this declared emergency. Providers should report problems to ProviderMCOInquiry@ky.gov if MCOs are not complying with this direction. In addition, this form can be utilized: https://chfs.ky.gov/agencies/dms/dpqo/mco-cmb/Documents/DMSFillableComplaintFormUpdate2017.pdf

12. What about 1915(c) waiver services and waiver providers and EPSDT Special Services?

DMS is completing changes to the 1915(c) waiver documents that will greatly expand telehealth within these services and waivers.

Pursuant to HHS' guidance, DMS will allow home health and waiver providers to provide services via telehealth as long as the provider continues to operate within their scope of practice and in compliance with licensure regulations – unless otherwise waived by state law.

13. What about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit services and telehealth?

To the extent that a service can be provided via telehealth via this benefit and to this population, DMS will allow for and facilitate that service via telehealth or telecommunications.

14. What about initial in-person meetings required for services such as occupational therapy, physical therapy, and speech and language pathology or PT 76 services?

If appropriate consistent with the guidance in these FAQs, the March 17, 2020 Provider letter, or executive orders, PT 76 can use telehealth. To the extent allowed or not restricted by executive order or licensing board action, DMS will allow for these facilities and providers to provide services via telehealth or other telecommunication method.

15. What about a MSW under billing supervision for DMS purposes?

A CSW under billing supervision can conduct their customary services – as appropriate – via telehealth if under the clinical supervision of an LCSW.

16. What about dentistry services?

DMS will expand teledentistry – when using the POS 02 code to include: screenings (CDT code D0190), assessments (D0191), and/or examinations (CDT codes D0120, D0140, D0145, and D0150) via teledentistry.

17. Will these changes be permanent?

Currently, DMS plans to restrict telehealth to previous requirements after this current emergency has ended. However, DMS will carefully consider any new developments and innovations in service delivery that occur during this time and may expand current regulations or interpretations to encourage any new efficiencies that are discovered. When

possible, DMS encourages providers to carefully document new approaches and efficiencies that improve outcomes and health of our members for future study.

New Entries as of 3-20-2020

18. What about vision services?

DMS will expand the services that can be utilized by vision services providers. When using POS 02, appropriate providers may bill using the following codes: 92002, 92012, 92004 and 92014.

19. What about any services that could be performed by telehealth within a BHSO III/residential AODE facility or a residential crisis stabilization unit?

DMS will allow for certain services provided within residential SUD or residential crisis stabilization units, clinical services provided within the residential service that are typically performed in person, to be done via telehealth.

Programs must remain compliant with licensure standards in terms of overall direct staffing. They are asked to engage in social distancing to the degree possible including limiting eliminating/reducing group activities, ending outside activities that are not therapeutically essential and restricting outside visitation. We also encourage screening of employees.

DMS would like to stress that services that are performed as part of the residential per diem are not eligible for additional reimbursement.

New Entries as of 3-23-2020:

20. What about pharmacy proof of delivery requirements or receipt of prescription requirements?
Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of 907 KAR 23:010 Section 7 relating to signature requirements through the end of the day on March 28, 2020.

After March 28, 2020, compliance with 907 KAR 23:010 Section 7 will be considered met if the pharmacist, pharmacy intern, pharmacy tech, or delivery driver writes “COVID 19” or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of prescription will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

21. What about DME proof of delivery requirements or receipt requirements?
Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of DME signature proof of delivery requirements or signature delivery requirements through the end of the day on March 28, 2020.

After March 28, 2020, compliance with DME signature proof of delivery requirements or signature delivery requirements will be considered met if the DME provider, appropriate staff person, appropriate provider, or delivery driver writes “COVID 19” or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of DME will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

22. What about billing supervision of providers?
DMS billing requirements relating to face-to-face supervision of staff may be done via telecommunications such as video conferencing or telephone if video conferencing is not available.

This alternative method of face-to-face supervision of staff will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

23. What about therapeutic rehabilitation program as an allowable telehealth service?
DMS is including therapeutic rehabilitation as a service within 907 KAR Chapter 15 that may now be provided telehealth as appropriate. Please see the list on question 1 that has been updated to include this service.

24. My practice is just beginning to utilize telehealth can you provide additional guidance?
Please see the answer to #2 above. DMS also recommends reviewing information available from the CHFS Telehealth Program on their website, available here: https://chfs.ky.gov/agencies/ohda/Pages/telehealth.aspx

DMS has already acted to broaden the availability of telehealth over the last year. But, with the filing of 907 KAR 3:300E, the department is acting to further broaden the availability of telehealth or telehealth-like services to the extent allowed by the nature of the service itself, and the provider's licensing board.

Any provider type that is allowed by their licensure board to practice telehealth can deliver any appropriate service that is within their scope of practice via telehealth or telehealth-like services.
Any service provided via telehealth should be billed with a POS of 02.

25. Can federally qualified health centers (FQHCs) or rural health centers (RHCs) provide medical and behavioral health services via telehealth?
FQHCs and RHCs can provide every appropriate service via telehealth as long as it is an approved service that the individual provider's licensure board allows for the provider providing the service.

For an FQHC or RHC to generate the PPS rate, the appropriate provider must provide the service to trigger the payment. A zero pay services code will continue to zero pay regardless of whether it is provided in person or via telehealth or telehealth-like service. Zero pay services would continue to get recorded for data and cost reports.

New entries as of 3/24/2020

26. We are an EPSDT provider of ST, OT & PT services. With the closing of certain facilities because of the Coronavirus we are wanting to provide our services through Telehealth. Will our current authorizations on clients still be valid and sufficient for the use of the Telehealth?
Yes, DMS will require that current authorizations apply to services provided via telehealth.

27. Can a physical and occupational therapist provide services in a home setting?
Yes, with the changes made to telehealth services over the last year – including the previously existing allowances under 907 KAR 3:170 - a physical and occupational therapist can provide any service via telehealth unless that service is prohibited by the providers licensure and licensure board or if it is residential in nature.

28. Can the PASRR process described pursuant to 907 KAR 1:755 utilize telehealth?
Yes. The PASRR process is eligible to be conducted via telehealth.

29. What about prior authorizations and telehealth?
Currently, DMS has directed the suspension of all prior authorizations for medical services from 2/4/2020 forward. Therefore, no med/surg claim, including behavioral health services, can be denied payment due to lack of prior authorization from DOS 2/4/20 forward.

This suspension of prior authorizations does not include pharmacy. In addition, any claim can still have a post-payment review performed.

New questions as of 3/25/2020

30. Can a certified alcohol and drug counselor (CADC) provide telehealth services?
Yes, a CADC can provide appropriate telehealth services not otherwise limited by a licensing board. A CADC provided telehealth service should be conducted under supervision of a licensed provider. During this emergency, a licensed provider may utilize e-signatures to demonstrate supervision.

31. Will Rural Health Clinics be reimbursed at their normal rate when providing telehealth or telehealth-like services? What about phone visits?
Yes. Please see question #25 for further clarification.
For telephone visits reimbursed via the Medicare-allowed G codes, as currently understood, the G codes (Medicare telephone codes) should not be a higher reimbursement than providing the service via telehealth (or "telehealth-like" service) with a POS of 02.

32. If a telehealth service is performed as a telehealth-like service is there any need to utilize one of the G codes when billing the claim?
No. The customary claim should be billed with a POS of 02. Billing the G code will not result in additional reimbursement.

33. What about prosthetic and orthotic services?
Those prosthetic and orthotic services that can be provided via telehealth should be provided via telehealth. DMS also would point to the DME guidance in FAQ #21, and will adopt a similar guidance for prosthetic and orthotic services that require the delivery of a good and the rest of the service can be delivered via telehealth.

After March 28, 2020, compliance with any signature proof of delivery requirements or signature delivery requirements will be considered met if the prosthetic or orthotic provider, appropriate staff person, appropriate provider, or delivery driver writes "COVID 19" or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

This alternative method of confirming receipt of prosthetic and orthotic supplies will expire 2 weeks after the expiration of the emergency declarations relating to COVID-19.

<u>New Questions as of 3/26/2020</u>

34. What documentation requirements beyond including the POS of 02 should providers observe when providing telehealth, or telehealth-like services via telephone or audio-only internet connection?
Providers may also want to include a notation as to whether the service was a telehealth service or a telehealth-like service delivered via telephone or audio-only internet connection.

35. Will EPSDT continue to reimburse for a Physical Therapist Assistant (PTA) to perform treatments (under the supervision of a PT available by phone if needed) if the treatment is performed via telehealth?
Yes. PTAs can perform treatments as telehealth or telehealth-like services under the supervision of a licensed PT. The supervision can be delivered via video, telephone, or audio-only internet connection.

36. "I work for a Narcotic Treatment Program, complying with the Department for Behavioral Health, Developmental and Intellectual Disabilities newly announced allowances for take home doses and counseling. Can I use telehealth and social distancing to reduce in-person contacts while providing this service?

Yes. Please refer to this guidance from the Department for Behavioral Health, Developmental and Intellectual Disabilities relating to allowances for counseling and take home doses:

"Physicians must use their own judgment and should balance the stability and needs of the patient with the steps needed to reduce the spread of COVID-19. The maximum take-homes and minimum counseling and screening

requirements are set out below. These parameters are not necessarily recommended and will not be suitable for all patients.:

- Phases 2, 3, 4 and 5
  - take-homes up to 28 doses for patients deemed stable
  - take-homes up to 14 doses for patients deemed less stable
  - monthly counseling
  - monthly screening
- Phase 1
  - take-homes up to 14 doses for patients deemed stable
  - take-homes up to 7 doses for patients deemed less stable
  - every other week counseling
  - every other week screening
- Entry Phase
  - take-homes 1 dose, for every other day
  - weekly counseling
  - weekly screening
- New Intakes are not eligible for this waiver/exception process
- Medical Directors may move a patient from Entry Phase to Phase 1 during this waiver if:
  - Patient is deemed stable by the Medical Director; and
  - Patient has been in treatment for a minimum of 60 days.
- The Medical Directors should make determinations on a case-by-case basis and, when appropriate for the patient:
  - Give a patient fewer take homes;
  - Increase the frequency of counseling; and
  - Increase the frequency of screenings.
- This waiver shall expire on May 1, 2020 and may be extended pending future analysis."

When any counseling services or other NTP services are provided via telehealth for an NTP service, the POS of 02 should be used when billing the bundle code. Additional reimbursement beyond the bundle code for this service will not be available, but telehealth and social distancing may be used when providing this service.

Updated 1915(c) Guidance for Telehealth:

The Division of Community Alternatives within DMS has released guidance about the use of telehealth during the COVID-19 declared emergencies.

37. Can providers deliver services remotely during the COVID-19 state of emergency?

Yes, DMS is allowing providers to deliver 1915(c) HCBS waiver services remotely for certain services. This can be done in situations where a participant is quarantined due to symptoms of or having been exposed to COVID-19 or as a precaution against spreading COVID-19. Services that could be provided via telehealth include:

- Physical, Occupational or Speech Therapy,
- Supported Employment,
- Behavior supports and counseling services,
- In-home services such as Personal Care or Homemaking (cueing and prompting support only)
- Case Management.

Hands-on direct care services can only be reimbursed if performed in person. Providers should also be vigilant in following their agency's infection control policies and Centers for Disease Control (CDC) guidance while providing in-home services to waiver participants.

Please see the COVID-19: Telehealth letter available at https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf for more information. All providers should work together to allow participants to receive services via telehealth when possible.

38. Should case managers/support brokers/service advisors conduct virtual visits with all waiver participants or only those who show symptoms of or have had known exposure to COVID-19?
To reduce the spread of COVID-19 in Kentucky, case managers and support brokers are allowed to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**), so long as the method used allows for direct interaction between the waiver participant and the case manager (e-mail or leaving a message is not considered interactive).

Please refer to the COVID-19: Telehealth letter available at https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf for more information.

39. Can case managers/support brokers/service advisors conduct virtual visits with waiver participants and their families in lieu of face-to-face visits even when no one in the participant's residence is showing signs of COVID-19? Some participants have a higher risk of contracting the virus due to age, health conditions or a compromised immune system and don't want to risk unintentional exposure.

On March 13, DMS began allowing case managers/support brokers/service advisors to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**). Please refer to the COVID-19: Telehealth letter available at https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf for more information.

40. What should a case manager do if a waiver participant needs to have a person-centered service plan meeting, either due to their annual level of care ending or the need for an emergency modification to their plan?
On March 13, DMS began allowing case managers and support brokers to conduct all visits via phone or using virtual options (**Note: Please refer to FAQ #3 above**). DMS issued the same guidance regarding assessments on March 16. Please refer to the following letters for more information.

- COVID-19: Telehealth Letter
  https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf
- ABI/MPW Assessments Letter
  https://chfs.ky.gov/agencies/dms/ProviderLetters/abimpwassessmentscovid19.pdf
- Model II Assessments Letter
  https://chfs.ky.gov/agencies/dms/ProviderLetters/modeliiassessmentscovid19.pdf.

The related case note should cite the COVID-19 state of emergency as the reason the meeting was not held face-to-face.

41. Case management providers are not required to have a license to provide services. Does the waiver stipulate only licensed case managers can bill for telehealth services?

The waiver does not require case managers to be licensed to provide services. Telehealth services are governed by KRS 205.510 (15), 205.559, 205.5591, 907 KAR 3:170, 907 KAR 3:300, and information contained in these FAQs and provider letters during the declared states of emergency.

See the COVID-19: Telehealth letter available at https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf for more information. Providers delivering services through alternative methods during the state of emergency should continue to bill under their waiver provider number as they usually do.

42. What kind of flexibility is DMS offering (1915 (c)) providers as they plan for or experience staffing shortages during the COVID-19 state of emergency? The reason for these shortages could include employees who are sick or employees who need to take time off to care for their families.
First, DMS is allowing providers to deliver services via phone and telehealth, as is appropriate. Please see the COVID-19 and Telehealth letter available at https://chfs.ky.gov/agencies/dms/ProviderLetters/1915ctelehealthcovid19providerletter.pdf for more information.
Other **temporary** changes DMS has made to the 1915(c) HCBS waivers include:

- Allowing employees, both agency and PDS, to begin providing services while they wait on the results of background check and pre-employment screenings.
    - If the results of a background check or other screening make the employee ineligible, services will be allowed to continue until an alternative employee is found. The only exception is in cases where the employee poses immediate jeopardy to the health, safety, and/or welfare of the participant or has a substantiated finding of past abuse, neglect or exploitation or violent felony.
- Suspending all conflict-of-interest related screening of immediate family members who wish to provide PDS. This gives providers and participants more options to cover gaps in care resulting from the COVID-19 state of emergency. More guidance on how to request an immediate family member as a PDS employee during the COVID-19 state of emergency will be forthcoming.
- Expanding the provider base by waiving requirements that out of state providers be licensed and located in Kentucky as long as they are licensed by another state's Medicaid agency.
- Expanding settings where services can be provided and opening up provider qualifications to allow different provider types to offer services outside of what they typically provide.

New Entries as of 3/27/2020

43. (UPDATED) Does the waiver of prior authorizations referenced in FAQ #29 apply to all medical services or only those related to COVID-19?
The waiver of prior authorization applies to all Medicaid behavioral and medical services. DMS is waiving these prior authorizations relating to medical services in order to enhance service delivery and system capacity for COVID-19 cases. The bulk of Medicaid prior authorization authority is permissive so that the program can address the potential for provider or recipient abuse, or governed by 907 KAR Chapter 17 via contracts with the managed care organizations. As such, DMS is not typically mandated to apply prior authorizations. DMS also received authority from the federal government to waive some Fee-for-Service prior authorizations via an 1135 waiver. Furthermore, DMS is asserting the authority under 907 KAR 3:300 Section 1(1) to waive PAs.

Prior authorizations relating to 1915(c) services are still required. However, the department is allowing services to be added to the plans 30 days retroactively.

New Entries as of 3/30/2020

44. What about those instances where a recipient fails to attend a scheduled appointment for an in-person or telehealth service?
At this time, DMS is not establishing a partial reimbursement for in-person or telehealth missed appointments.

45. Are services provided by the Ky Moms Maternal Assistance Towards Recovery (MATR) program allowable via telehealth?
Yes, DMS allows services provided by the Ky Moms MATR program to be performed via telehealth. Services in this program that are allowable telehealth services include those services that are billed via Medicaid codes H0024, H0025, and H0006.

46. Are prior authorizations suspended for all laboratory services or just those related to COVID-19?
During this public health emergency, DMS has suspended all laboratory services prior authorizations. Post payment review can still be conducted on any claim.

47. (UPDATED) Can you provide further information about the Medicare telephone "G" codes that are now allowable?
Please see FAQ #8 above for additional information. The G codes are limited in relation to the more expanded "telehealth-like" service option that DMS is utilizing for the duration of this emergency.

These codes (G2010 and G2012) are typically limited to MDs, APRNs, and DOs or other providers who code for evaluation and management codes. DMS is reimbursing these codes the same as Medicare.

New Entries as of 3/31/2020

48. Will DMS expand telephone interactions involving CPT codes 99441, 99442, and 99443?
Yes, DMS is now allowing these CPT codes to be covered for telephone interactions.

New Entries as of 4/1/2020

49. Is texting an approved method of delivering a "telehealth-like" service?
Generally no:

- A provider and recipient cannot text as the only communication for a "telehealth-like" service or a G code.
- A text could be used to initiate a session (provide a link to a secure or allowable video or audio connection).
- A text could also be used to support or enhance a telehealth or telehealth-like service that is a telephone or video conversation. For example, a telephone call could be enhanced with a texted picture or video.

Provider MCO COVID-19 FAQs

DMS has received questions relating to managed care and provider interactions. This portion of the document reflects instructions given to MCOs relating to the implementation of emergency regulations and orders relating to the delivery of Medicaid Services. This document is numbered separately from the Telehealth Provider FAQs.

Entries as of March 31, 2020

1. What services can be waived for cost sharing?

A. Cost sharing for all services is to be waived.

2. Is prior authorization required?

A. DMS has directed the suspension of all prior authorizations for medical and behavioral services until the end of the COVID-19 crisis. If providers continue to call for PA you may review for medical necessity. Post-payment review to determine medical necessity is permitted once the emergency orders are lifted. Providers do not need to be formally notified. The suspension of prior authorizations does not include pharmacy benefits. Any claim that comes in with a DOS of 2/4/2020 that requires PA per the MCO PA list, should not be denied for no PA. If the PA was denied for medical necessity on DOS 2/4/2020 or greater, and the provider submits the claim for payment, you may deny the claim for not meeting medical necessity.

3. What lab tests are covered?

A. HCPCS code (U0001) should be used to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for COVID–19. HCPCS billing code (U0002) allows laboratories to bill for non–CDC laboratory tests for COVID–19. This second HCPCS code should be used for tests developed by these additional laboratories when submitting claims to Medicaid. HCPCS code U0002 will be reimbursed at an interim fee.

4. What is the effective date for payment of claims with COVID-19 related codes?

A. DMS will follow Medicare policy regarding reimbursement for codes U0001, U0002, G2012, and G2010. The codes will be retroactively effective on February 4, 2020 but will not be billable until after April 1, 2020.

5. Are early refill on prescriptions allowed?

A. Yes. Early refills are allowed for 30, 60 or 90 day supply of medication. Practitioners should be encouraged to prescribe 90-day supplies of long-term maintenance medications for individuals in quarantine. MCOs are to apply guidance to the practitioners for 90-day supplies.

6. Is free home delivery of medications allowed?

A. Yes**.** Pursuant to 907 KAR 3:300E, and the emergency declarations and orders issued during the month of March 2020, DMS is waiving enforcement of 907 KAR 23:010 Section 7 relating to signature requirements through the end of the day on March 28, 2020.
After March 28, 2020, compliance with 907 KAR 23:010 Section 7 will be considered met if the pharmacist, pharmacy intern, pharmacy tech, or delivery driver writes “COVID 19” or something of similar status to denote the delivery and receipt of prescriptions on the customary location for patient signature. Such confirmation should be documented and retrievable upon audit.

7. A non-par policy that requires all non-participating providers to receive prior authorization approvals for services with a few exceptions to include emergency services. Is it KDMS’ expectation that MCOs will lift these auth requirements for non-network providers related to these diagnoses codes?

A. Yes

8. Based on the guidance provided by KDMS, does the lifting of prior authorization for the coronavirus diagnoses codes (all dx) also include air ambulance services?

A. Yes

9. Does the 30, 60 and 90 day early refill policy apply to all members or members with corresponding coronavirus diagnoses?

A. All members

10. Can you please advise if the intention for a blanket extension of all existing PAs

A. Any PA that may have a limited timeframe and would expire prior to May 31, 2020, should be extended, such as therapy. Another example could be, if someone has an elective procedure scheduled during this time period that required an authorization. The procedure was postponed due to the Governor's directive, therefore the authorization should be extended.

11. Is modifier 02 to be used with the G codes?

A. Yes

12. Within the 1135 Waiver application, the submission outlined that DMS is seeking a waiver relative to the replacement of DME equipment w/o physician's order or medical necessity determination. Would you please confirm that this is referring to the requirement that DME suppliers must have a signed certificate of need (or medical necessity) before the provider can fulfill the request?

A. Yes – flexibility to replace DME without MD order for medical necessity; continue to monitor

13. With regards to the waiver request to exempt providers from certain credentialing mandates, will you please confirm if it is the expectation that MCOs allow providers without active KY Medicaid IDs be paid for both COVID-19 and non COVID-19 services?

A. Yes

14. Does DMS expect the MCOs to adjust claims that were already paid/processed with the date of service 2/4/2020 forward?

A. No

15. Have rates for G codes been published?

A. Confirmed the rates are on the fee schedules and are published on the website:
Physician Fee Schedule can be found on pages 349-350 at
https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2020%20Physician%20Fee%20Schedule.pdf
Clinical Lab Fee Schedule can be found on page 33 at
https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/2020ClinicalLabRates.pdf

16. For the items that normally have a limit (EX: 10 per month), do we continue to override the authorizations even though the limit has been met?

A. If you receive a request to extend, you may review for medical necessity. The claim should not deny for no PA.

17. What about drugs that are administered thru the medical benefit (physician administered and outpatient infused)? Are they exempt from the 1135 waiver PA removal requirements as well?

A. As part of the 1135 waiver, DMS has waived all prior authorizations (PAs) for all medical and behavioral services. This will include all PAs for products on the physician-administered-drug list maintained by each MCO. These are a medical benefit. The only exemption is for drug products belonging to the High Cost Drug Stop Loss Program (HCDSLP). Products

in the HCDSLP (Spinraza and Zolgensma) should have their prior authorizations remain on to ensure medical necessity and appropriate use of these products.

18. Please confirm that auth extensions should only be through 5/31/20.
A. Any PA that may have a limited timeframe and would expire prior to May 31, 2020, should be extended, such as therapy. Another example could be, if someone has an elective procedure scheduled during this time period that required an authorization. The procedure was postponed due to the Governor's directive, therefore the authorization should be extended.

19. Is it KDMS' expectation that the placing facility will bill for the services rendered in an unlicensed facility, having no impact on claims processing for the MCO?
A. Yes

20. Is the DMS proceeding with allowing members 120 days to submit a request for State Fair Hearings or will DMS chose a different timeframe?
A. We will begin with the 120 day timeframe and amend in the future, if necessary

21. Is it DMS' expectation that MCOs will be held to one day to resolve a member appeal or will you still allow 2 business days?
A. We will allow 2 business days

UL Health | Telehealth

TELEHEALTH:

MISCELLANEOUS DOCUMENTS

MARCH 19 - JUNE 30, 2020

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

Andy Beshear
Governor

275 East Main Street, 6W-A
Frankfort, KY 40621
www.chfs.ky.gov

Eric C. Friedlander
Acting Secretary

Lisa D. Lee
Commissioner

March 11, 2020

TO: All Medicaid Providers
Provider Letter A-105

RE: COVID-19 Guidance

Dear Medicaid Providers:

The Department for Medicaid Services (DMS) continues to monitor COVID-19 and is implementing policies to reduce barriers to care for our members, limit the administrative burden for providers, and reduce the number of infected individuals within our communities. Specific policies related to COVID-19 testing and treatment include:

- Waiving all cost sharing for services associated with COVID-19, including:
  - Claims with diagnosis codes B97.29 (actual diagnosis), Z03.818 (possible exposure) or Z20.828 (actual exposure). Providers should follow CDC-ICD-10-CM Official Coding Guidelines, found at this link https://www.cdc.gov/nchs/data/icd/ICD-10-CM-Official-Coding-Gudance-Interim-Advice-coronavirus-feb-20-2020.pdf, when selecting a diagnosis code to ensure proper reporting.
  - Laboratory copayments – please note: HCPCS code (U0001) should be used to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for COVID–19. HCPCS billing code (U0002) allows laboratories to bill for non–CDC laboratory tests for COVID–19. This second HCPCS code should be used for tests developed by these additional laboratories when submitting claims to Medicaid. HCPCS code U0002 will be reimbursed at an interim fee.
  - Medications used to treat underlying respiratory disease.

(continued)

- Encouraging the use of telehealth, when possible. Currently, telehealth coverage and reimbursement requirements are outlined in 907 KAR 907 3:170.

- In order to reduce in-person trips to medical facilities, DMS will add the following codes on a temporary basis for brief communications with established patients:

    - G2012 to be utilized for telephone calls between physician and patient, including FaceTime; and
    - G2010 to be utilized for remote evaluation, such as email, of recorded video or images submitted by a patient.

- Eliminating prior authorizations for COVID-19 related services, including hospitalizations and office visits.

- Allowing early refill to allow 30, 60, or 90 day supply of medication. Practitioners should consider 90-day supplies of long-term maintenance medications for individuals in quarantine. Medicaid Managed Care questions regarding policy and guidance for 90-day supplies should be directed to the enrollee's Medicaid Managed Care Plan.

DMS will follow Medicare policy regarding reimbursement for codes U0001, U0002, G2012, and G2010. The codes will be retroactively effective on February 4, 2020 but will not be billable until after April 1, 2020.

COVID–19 can be spread from infected individuals to others through close personal contact and through the air by coughing and sneezing. Providers should encourage their patients to practice good hand washing, avoid touching their faces as much as possible, and avoid unnecessary contact with individuals who are ill.

We have worked closely with our Managed Care Organizations (MCO) regarding the development of these policies and they, too, are implementing the same policies related to identification and treatment of COVID-19.

We will continue to coordinate with federal and local partners to respond to COVID-19 as information becomes available and will provide updates as necessary.

For up-to-date information regarding COVID-19, you may visit www.kycovid19.ky.gov or call the COVID-19 hotline number at 1-800-722-5725.

Thank you,

Lisa D. Lee, Commissioner

ANDY BESHEAR
GOVERNOR

EXECUTIVE ORDER

Secretary of State
Frankfort
Kentucky

2020-220
March 9, 2020

STATE OF EMERGENCY RELATING TO INSURANCE

WHEREAS, on March 6, 2020, a case of the novel coronavirus (COVID-19) was confirmed in the Commonwealth, and, as of the date of this Executive Order, three additional cases of COVID-19 have been confirmed in the Commonwealth; and

WHEREAS, this condition continues to endanger public health and safety; and

WHEREAS, it is essential to the public health and safety that the citizens of the Commonwealth have access to testing for COVID-19, and that the cost of such testing does not create a barrier for consumers; and

WHEREAS, the Kentucky Department of Insurance is charged by law with the duty to administer KRS Chapter 304, which includes the supervision, regulation, and discipline of insurance companies, agencies, producers, and public adjusters licensed to operate and conduct business in the Commonwealth of Kentucky and with enforcing a variety of insurance-related statutes and regulations; and

WHEREAS, the Kentucky Department of Employee Insurance is charged by law with the duty to administer the state employee health plan under KRS Chapter 18A; and

WHEREAS, in order to respond to the emergency and to protect and safeguard the public health, safety, and welfare of the citizens of the Commonwealth of Kentucky, it is necessary to adjust certain insurance related rules and regulations on a temporary and short term basis;

NOW, THEREFORE, I, Andy Beshear, Governor of the Commonwealth of Kentucky, by virtue of the authority vested in me by the Constitution and laws of the Commonwealth of Kentucky, including Chapter 39A of the Kentucky Revised Statutes, do hereby Order and Direct that:

1. The Commissioner of the Kentucky Department of Insurance shall temporarily waive, suspend, and/or modify the operation of any statute or administrative

regulation currently in place under the purview of the Kentucky Department of Insurance in order to best serve the interest of the public health, safety, and welfare during this period.

2. All insurers shall waive all cost-sharing including copayments, coinsurance, and deductibles for screening and testing for COVID-19 as specified by the Centers for Disease Control and Prevention (CDC), including hospital, emergency department, urgent care, provider office visits, lab testing, telehealth, and any immunizations that are made available.

3. All insurers shall waive any prior authorization requirements for screening and diagnostic testing for COVID-19 and respond to any requests for treatment of COVID-19 on a timely basis.

4. All insurers shall ensure that provider networks are adequate to handle an increase in the need for health care services, including by offering access to out-of-network services where appropriate.

5. All insurers shall notify all contracted providers that the insurer is waiving the cost-sharing and prior authorization requirements, and ensure that information regarding the waivers is provided to customer service centers, nurse advice lines, and others so that proper information is provided to insured citizens.

6. All insurers shall ensure that the insurer's websites contain complete and accurate information related to coverage for COVID-19 screening, testing, and treatment.

7. When prescription drug coverage exists for insured citizens, insurers shall allow insured individuals to obtain refills of their prescriptions even if the prescription was recently filled, consistent with approval from patients' health care providers and/or pharmacists.

8. The Kentucky Department of Employee Insurance shall coordinate with the Kentucky Department of Insurance to ensure that the provisions of this Executive Order apply to participants in the state employee health plan.

This Order shall be in effect for the duration of the State of Emergency herein referenced, or until this Executive Order is rescinded by further order or by operation of law.

ANDY BESHEAR
GOVERNOR

EXECUTIVE ORDER

Secretary of State
Frankfort
Kentucky

2020-220
March 9, 2020

This Order is effective March 9, 2020.

ANDY BESHEAR, Governor
Commonwealth of Kentucky

MICHAEL G. ADAMS
Secretary of State

STATE OF INDIANA

EXECUTIVE DEPARTMENT
INDIANAPOLIS

EXECUTIVE ORDER 20-05

FOR: **HELPING HOOSIERS DURING THE PUBLIC HEALTH EMERGENCY DECLARED FOR THE CORONAVIRUS DISEASE 2019 OUTBREAK**

TO ALL WHOM THESE PRESENTS MAY COME, GREETINGS:

WHEREAS, on March, 6, 2020, I issued Executive Order 20-02 which declared a public health emergency exists throughout the State of Indiana as a result of the coronavirus disease 2019 (COVID-19) outbreak in the United States and a confirmed report that a fellow Hoosier had contracted this virus;

WHEREAS, on March 13, 2020, the President of the United States declared a national emergency in connection with COVID-19;

WHEREAS, since the declaration of a public health emergency, I have announced additional steps being taken to address and respond to the emergency including, but not limited to, signing Executive Order 20-03 and Executive Order 20-04, which are necessary and proper actions to protect the health, safety, and welfare of all Hoosiers in connection with the continuing and evolving threat posed to public health by COVID-19;

WHEREAS, this Executive Order is a supplement to, and deemed to be part of, Executive Orders 20-02, 20-03, and 20-04;

WHEREAS, as Governor, I have broad authority and powers, under Indiana law, to declare and respond to public health emergencies on behalf of our State, including, but not limited to: (a) making, amending, and rescinding the necessary orders, rules, and regulations to carry out Indiana's Emergency Management and Disaster Law, Ind. Code § 10-14-3 *et seq.*; and (b) suspending the provisions of any regulatory statute prescribing the procedures for conduct of state business, or the orders, rules, or regulations of any state agency if strict compliance with any of these provisions would in any way prevent, hinder, or delay necessary action in coping with the emergency; and

WHEREAS, the following actions are necessary and proper to address the significant economic impact of this public health emergency upon Hoosiers and to protect and preserve the economic health of Hoosiers and this state.

NOW, THEREFORE, I, Eric J. Holcomb, by virtue of the authority vested in me as Governor by the Constitution and the laws of the State of Indiana and for the duration of this public health emergency unless otherwise specified, do hereby order that:

1. Department of Workforce Development (DWD):

   A. The DWD shall interpret, consistent with federal law, Indiana's unemployment laws to provide benefits to claimants displaced by COVID-19.

   B. The DWD shall not assess certain experience rate penalties to employers as a result of employees receiving unemployment benefits related to COVID-19.

   C. If the DWD finds that if a claimant's untimely filing was due in part to the COVID-19 pandemic, the DWD shall not deny the claimant's benefits for that reason.

   D. The DWD shall permit individuals to continue to accrue unemployment eligibility if they elect to take leave due to COVID-19.

E. The DWD shall seek federal authorization to provide unemployment benefits to those individuals who may not otherwise be eligible for unemployment benefits because they were short-term employees who now find themselves out of work due to COVID-19.

2. Family and Social Services Administration (FSSA):

A. FSSA shall waive all premium payment requirements for the Healthy Indiana Plan (HIP), and the Children's Health Insurance Program (CHIP).

B. FSSA shall waive upfront job search requirements for initial eligibility for Temporary Assistance to Needy Families (TANF) benefits, and re-investigation requirements for annual renewal of TANF benefits.

C. FSSA shall delay renewal processing for all Medicaid and HIP recipients, if approved by the federal Centers of Medicare and Medicaid Services.

D. FSSA shall suspend Telehealth restrictions and requirements for face-to-face encounters for healthcare services and prescribing which will permit the increased use of Telehealth for statewide services such as Medicaid-covered services, mental health services, and substance use disorder treatment and prescribing.

E. FSSA shall permit Opioid Treatment Providers to increase the limits for take-home medications from 6 days to 30 days, or in the alternative, the maximum amount permitted by the federal Substance Abuse and Mental Health Services Administration.

F. FSSA is granted the authority to modify or suspend its provider staffing, enrollment, and hiring requirements for providers and facilities enrolled with the Division of Mental Health and Addiction, Division of Disability and Rehabilitative Services, and Division of Aging.

3. Indiana Department of Veterans Affairs (IDVA):

A. IDVA shall permit veterans to qualify for awards from the Military Family Relief Fund (MFRF) for basic needs such as food, rent, mortgage and utilities even if the veteran does not satisfy the requirements that: (1) the veteran's hardship be connected to his or her military service; and (2) the veteran served during a time of national conflict or war.

B. The Director of the Department of Veterans Affairs may approve MFRF awards in excess of $2,500 during the public health emergency.

4. Department of Education (DOE):

A. All K-12 schools in Indiana, public or private, shall close and cease in-person instruction through May 1, 2020. All schools are encouraged to work with their local governments and county health departments to determine appropriate community uses for school facilities.

B. All state-mandated assessments are cancelled for the 2019-2020 academic year.

5. Essential Services

A. Providers of gas and electric utilities, broadband, telecommunication, water and wastewater services are prohibited from discontinuing service to any customer in the state as these services are essential to Hoosiers and Hoosier businesses particularly during this state of public health emergency.

6. Department of Revenue (IDOR):

A. The Indiana Department of Revenue shall take such action as is necessary to ensure Indiana conforms to the relief provided by the United States Treasury Department and Internal Revenue Service under Notice 2020-17 by providing for an extension of time related to state income tax liabilities.

B. Property taxes remain due on May 11, 2020, however counties are to waive penalties on payments made after May 11, 2020, for a period of 60 days. This waiver does not apply to tax payments which have been escrowed by financial institutions on behalf of property taxpayers.

C. Subject to the approval of the IDOR, manufacturers making donations of medicine, medical supplies, or other goods in furtherance of fighting the COVID-19 pandemic will not be subject to Indiana use tax on those items donated. Further, subject to the approval of the IDOR, groups or organizations that are not manufacturers who make any donations of medicine, medical supplies, or other goods will not incur a use tax obligation if sales tax had not been paid on such items. In either instance, such donations shall not be construed to be a retail transaction subject to sales or use tax. Donation of such items will not entitle the donor to a refund of any sales or use tax previously paid to the department or to a vendor.

D. The IDOR may waive any penalties and interest that are directly related to taxes, estimated payments or other amounts due if the due date for the underlying tax, estimated payment or other amount due is extended in response to the COVID-19 pandemic public health emergency, and such waiver shall continue for the duration of the extension.

7. Office of Community and Rural Affairs (OCRA):

A. Community Development Block Grant funds may be redirected to assist with COVID-19 needs based on guidance from the United States Housing and Urban Development.

8. Bureau of Motor Vehicles (BMV):

A. The Commissioner shall extend deadlines for renewal of driver's license or identification cards, vehicle registration renewals, title transactions, salvage titles, and off-road vehicle and snowmobile titles by suspending the imposition of administrative penalty fees (late fees).

B. Suspension of the provision requiring a branch be open in every county.

C. The 45-day notification requirement of the BMV found under Ind. Code § 9-25-5-2 as to those person(s) who the Bureau must manually notify to submit evidence of financial responsibility as a result of being listed as an operator in a motor vehicle accident report is waived.

9. Indiana State Department of Health (ISDH):

A. The Commissioner of ISDH shall seek waivers of the physical presence requirement for certification and re-certification appointments for Women, Infants, and Children (WIC) program; seek waivers to extend certifications periods to keep issuing benefits while staff develop the capacity to offer telephone or video certification appointments; and identify and seek waivers for any additional rules that are impeding service or for any requirements that are not feasible to meet.

B. ISDH shall permit the informal hearing for involuntary relocation determinations to be held at locations other than the resident's healthcare facility.

C. The Commissioner of ISDH is authorized to waive requirements of the nursing home certificate of need statute, pursuant to Ind. Code § 16-29-7, as the Commissioner deems necessary to respond to COVID-19 issues for nursing homes and on terms and conditions appropriate for each situation.

10. Public Licensing Agency (PLA):

A. Suspension of the requirement that a health care provider hold an Indiana license if he or she: (1) has an equivalent license from another State, and (2) is not suspended or barred from practice in that State or any State.

B. Mental health professionals are permitted to practice via telemedicine.

C. Advanced Practice Registered Nurses are permitted to provide services in multiple locations while under a single written collaboration agreement.

11. Insurance Coverage for Hoosiers and Department of Insurance (IDOI):

A. The Commissioner shall request insurers to institute a 60-day moratorium on policy cancellations for non-payment of premiums, which will apply to all lines of business. However, this moratorium would not suspend a policyholder's responsibility for continuing to make premium payments.

B. The Commissioner of the IDOI shall request health insurers cover COVID-19 testing without requiring prior authorization.

C. The Commissioner of the IDOI shall request health insurers not increase prices or coverage costs involving medical care given for COVID-19.

D. Suspend the Indiana licensure requirement under the Indiana Medical Malpractice Act to permit health care providers licensed by another state to provide care in Indiana and be eligible for coverage from the Indiana Patient Compensation Fund.

12. Department of Administration (IDOA):

A. Suspension of procurement rules as they apply to the purchase of goods, equipment and services by state and local governmental entities needed to respond to the COVID-19 public health emergency.

13. All State Agencies

A. Any state agency as defined by Ind. Code § 4-2-6-1(a)(2) is hereby granted authority to extend any non-essential deadline of their agency for a period of no longer than 60 days if deemed necessary to respond to the threat of COVID-19.

B. The head of any state agency as defined by Ind. Code § 4-2-6-1(a)(2) with authority to promulgate rules is authorized to waive, suspend, or modify any existing rule of their agency where the enforcement of which would be detrimental to the public welfare during this emergency, notwithstanding the provisions of the Administrative Orders and Procedures Act (AOPA) or any law to the contrary for the duration of this Executive Order, subject to my prior approval.

C. All state agencies as defined by Ind. Code § 4-2-6-1(a)(2) shall publish a summary of and guidance for all benefits available or modified related to any and all actions taken by departments and agencies pursuant to this Executive Order. Such publication shall, at a minimum, be posted on the state agency's website.

IT IS SO ORDERED.

IN TESTIMONY WHEREOF, I, Eric J. Holcomb, have hereunto set my hand and caused to be affixed the Great Seal of the State of Indiana, on this 19th day of March, 2020.

Eric J. Holcomb
Governor of Indiana

ATTEST: Connie Lawson
Secretary of State

Advisory on Prescribing During Declaration of Emergency

In response to the recent novel coronavirus (COVID-19) pandemic and subsequent declaration of State of Emergency by Governor Andy Beshear, the Board has received inquiries from licensees about prescribing controlled substances during this period. The Board would like to remind all of its licensees who are prescribing controlled medications (whether Schedule IIs, IIIs, IVs or Vs) of KRS 311.597(4) which calls upon licensees to conform with acceptable and prevailing medical practices and the provisions of 201 KAR 9:260 Section 2(2), which states

> *If a physician is unable to conform to professional standards for prescribing or dispensing controlled substances due to circumstances beyond the physician's control, or the physician makes a professional determination that it is not appropriate to comply with a specific standard, based upon the individual facts applicable to a specific patient's diagnosis and treatment, the physician shall document those circumstances in the patient's record and only prescribe or dispense a controlled substance to the patient if the patient record appropriately justifies the prescribing or dispensing of a controlled substance under the circumstances.*

The standards of acceptable and prevailing medical practices that apply under normal circumstances may not apply in a state of emergency. During this time it is particularly important that licensees responsibly exercise their best clinical judgment on a case-by-case and patient-by-patient basis, balancing a variety of factors (including being mindful not to contribute to the ongoing opioid epidemic). When considering whether to have an in-person patient visit, licensees should ask themselves whether the service provided would be retrospectively deemed necessary if the patient were to become infected by COVID-19 as a result of the visit. Where possible, use of telehealth technologies should be considered in an effort to limit and contain the spread of COVID-19.

For instance, the current but temporary state of emergency may be a circumstance in which it would not be appropriate to require a patient to come in prior to refilling a prescription. The physician should consider whether the patient has a history of compliance with treatment directives; whether the patient is established and stable on the dose of medication. If it is a matter of refilling the same medication at the same dosage for an established patient, in order to avoid exposing the patient or others to the current environment, it may be appropriate to authorize a refill without an in-person visit.

For patients beginning treatment of opioid use disorder with buprenorphine, in order to avoid exposing the patient or others to the current environment, it may be appropriate to screen the patient using telehealth technologies in order to determine whether an in-person examination is warranted. In this state of emergency, telehealth may be a clinically sound approach for some patients and some conditions, but for others it may not. It is appropriate to use telehealth resources to help make such a determination on patient-by-patient basis.

The Board recognizes that the current state of emergency is a fluid environment requiring extraordinary effort, physical and mental, from many of its licensees. The Board understands the fine line of balancing treatment of individual patients with the protection of others and are grateful for its licensees' efforts to exercise sound judgment in unsound circumstances.

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