THE UNIVERSITY OF KANSAS HEALTH SYSTEM
Care Collaborative

Telehealth Implementation Toolkit for Rural Ambulatory Practice

Overview

The Telehealth Implementation Toolkit is provided to help you implement telehealth services thoughtfully in a rural, ambulatory setting amidst the COVID-19 public health emergency (PHE).

The first half of the Toolkit presents telehealth primers on the most recent federal and state policies. These increase access to telehealth services for providers and patients alike in a wide variety of rural settings to stem the spread of the COVID-19 virus. It creates a framework that defines telehealth possibilities and the specifics necessary to administer and receive payment for them. The second half of the Toolkit is intended to prompt consideration of plans, decisions, and steps that will help you define and accomplish your goals using telehealth swiftly and sustainably in this new healthcare context.

Content draws upon guidance and approaches to implementing telehealth published online by multiple resources, the tools and experience we gained successfully implementing the Kansas Rural Telebehavioral Health Network (TBHN) with 10 Care Collaborative ACO sites to-date, over the past 18 months, and tools hailing from recent efforts at The University of Kansas Hospital to accomplish a swift and effective transition in health care delivery using telehealth to sustain safe, quality care and improve outcomes for its patients.

You'll receive notification of updates to the Toolkit as they're made, along with a link to the Care Collaborative webpage where you can access them.

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THE UNIVERSITY OF KANSAS HEALTH SYSTEM
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Section 1: What Matters Now – A COVID-19 Telehealth Policy Primer

Overview

Substantial changes in American's healthcare system have emerged and rapidly evolved since mid-March when the COVID-19 national public health emergency was declared. The unpredictable nature and rapid spread of the coronavirus catapulted telehealth to the forefront of healthcare.

Federal and Kansas policy primers follow that clarify the newest rules of telehealth to inform and facilitate the implementation of telehealth in rural ambulatory practice. Links to resources are identified at the end and/or throughout the primers.

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Federal Medicare Policy Primer

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COVID-19 Pandemic:
Expanded Medicare Coverage for Telehealth and Other Non-Face-To-Face Services

For years, only a handful of physicians furnished telehealth services. Now, in only a few weeks, many physician practices have transitioned to telehealth-based care delivery. This dramatic shift in response to the COVID-19 pandemic has been facilitated by the significant expansion of Medicare coverage for these services.

Historically, reimbursement for telehealth services under the Medicare Physician Fee Schedule has been extremely limited. Under Section 1834(m) of the Social Security Act, a service delivered using telehealth must meet five requirements to be covered by Medicare:

(1) The **geographic** requirement. The beneficiary must reside in a rural area.

(2) The **location** requirement. The beneficiary must be physically present at a healthcare facility when the service is provided.

(3) The **service** requirement. The service provided must be listed as an approved telehealth service (as defined by CPT or HCPCS code).

(4) The **technology** requirement. The service must be provided using a telecommunications technology with audio and video capabilities that permit real-time interactive communication.

(5) The **provider** requirement. The service must be provided by an eligible provider, including physicians, non-physician practitioners, clinical psychologists, clinical social workers, registered dieticians, and nutrition professionals.

As part of its initial response to the COVID-19 pandemic, Congress gave the Secretary of Health and Human Services new authority to waive the geographic and location requirements during the national public health emergency (PHE).

By exercising this authority, the Secretary expanded Medicare telehealth coverage for services furnished to a beneficiary in his or her home (or any other location) without regard to whether the beneficiary resides in a rural area. Additionally, the Centers for Medicare & Medicaid Services (CMS) has published an interim final rule (IFR) further eliminating barriers to telehealth adoption during the PHE.

The details regarding expanded telehealth coverage during the PHE are addressed in the following sections.

List of Approved Telehealth Services

In the IFR, CMS expanded the list of approved telehealth services from 100 to 180 for the duration of the PHE. The newly added services include the following:

Service Category	**CPT Codes**
Emergency Department Visits	99281 – 99285
Initial & Subsequent Observation & Observation Discharge Day Management	99217 – 99220 99224 – 99226 99234 – 99236
Initial Hospital Care & Hospital Discharge Day Management	99221 – 99223 99238 – 99239
Initial Nursing Facility Visit & Nursing Facility Discharge Day Management	99304 – 99306 99315 – 99316
Critical Care Services	99291 – 99292
Domiciliary, Rest Home, or Custodial Care Services	99327 – 99328 99334 – 99337
Home Visits	99341 – 99345 99347– 99350
Inpatient Neonatal & Pediatric Critical Care	99468 – 99469 99471 – 99473 99475 – 99476
Initial & Continuing Intensive Care Services	99477 – 99480
Care Planning for Patients with Cognitive Impairment	99483
Group Psychotherapy	90853
Psychological & Neuropsychological Testing	96130 – 96133 96136 – 96139
Therapy Services *NOTE: As CMS notes in the IFR, Section 1834(m) does not authorize physical therapists, occupational therapists, or speech-language pathologists to bill for services furnished via telehealth. Thus, these services are reimbursable only if furnished by a physician or non-physician practitioner.*	97161 – 97168 97110 97112 97116 97535 97750 97755 97760 – 97761 92521 – 92524 92507
Radiation Treatment Management Services	77427

All Medicare beneficiaries are eligible to receive any listed telehealth services to the same extent they are eligible to receive the service on a face-to-face basis. In the IFR, CMS eliminated the limits on the frequency with which certain telehealth services can be provided within a specified time period. This change impacts subsequent inpatient visits, subsequent nursing facility visits, and critical care consultation services.

Regarding the selection of the appropriate E/M code for telehealth services furnished to a patient in his or her home, CMS provides the following guidance in the IFR:

The CPT codes describing E/M services reflect an assumption that the nature of the work involved in [E/M] visits varies, in part, based on the setting of care and the patient's status. Consequently, there are separate sets of E/M codes for different settings of care.... We expect [providers] to use the E/M code that best describes the nature of the care they are providing, regardless of the physical location or status of the patient. Under ordinary circumstances, we would expect the kind of E/M code reported to generally align with the physical location or status of the patient. In the context of the PHE, we recognize that the relationship among the setting of care, patient status, and kind of E/M code reported may depend on the needs of local communities and the capacity of local health care institutions.

In addition to expanding the list of covered services, CMS in the IFR permitted telehealth to serve as a substitute for certain required face-to-face interactions between a patient and an eligible provider. This includes: (1) clinical examination of the beneficiary's vascular site as a component of the end-stage renal disease monthly capitated payments, (2) face-to-face visits with inpatient rehabilitation facility patients, and (3) face-to-face visits for hospice re-certification. Also, when direct supervision by a practitioner is required for a service to be billable, such supervision may be accomplished using telehealth (rather than being physically present in the same suite of offices).

Telehealth Technology Requirements

To bill for telehealth services, a practitioner must use an interactive audio and video system. Telephone-only services may be reimbursed as virtual check-ins or telephone evaluation and management services; further details follow.

On March 17, the agency responsible for HIPAA enforcement, the HHS Office for Civil Rights (OCR), issued a Notification of Enforcement Discretion relating to the emergency telehealth waiver. To prevent HIPAA from creating a barrier to telehealth usage, the OCR will not impose penalties for noncompliance with the regulatory requirements in connection with the good faith provision of telehealth. According to the OCR, a practitioner may use any non-public-facing remote communication product, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, and Skype. Not included are Facebook Live, Twitch, TikTok, and similar public-facing video communication applications.

Telehealth Eligible Providers

Generally, an eligible provider must be licensed in the state in which the patient receiving telehealth services is present. CMS has waived this requirement for the duration of the PHE, so long as the eligible provider is properly licensed in his or her home state.

Regardless of any CMS waiver, however, applicable state law still may require local licensure to provide telehealth services to a person located in that state. Several states have waived these requirements for the duration of the PHE, albeit on different conditions. The Center for Connected Health Policy maintains an up-to-date resource regarding such state action.

Billing and Reimbursement for Telehealth Services

In announcing the telehealth waiver March 17, CMS stated telehealth services would be reimbursed at the lower facility rate, even for eligible providers regularly practicing in office settings (as opposed to hospital outpatient departments). CMS directed eligible providers to use POS 02 without any modifier in billing for telehealth services.

In the March 31 IFR, however, CMS changed course, announcing that telehealth services would be reimbursed at the higher non-facility rate if furnished in a physician practice. To accomplish this, CMS directed eligible providers to discontinue use of POS 02, instead listing the location "that would have been reported had the service been furnished in person…if not for the [public health emergency] COVID-19 pandemic." In addition, eligible providers now should include the 95 modifier on claims for telehealth services. CMS noted, however, claims would not be denied if submitted with POS 02 and no modifier, but would be paid at the lower facility rate.

Generally, providers are required to include the CR (catastrophe/disaster related) modifier on claims for services provided under an emergency waiver. CMS, however, has directed eligible providers not to include the CR modifier on any telehealth claims.

Also in the IFR, CMS advised that for office/outpatient E/M visits furnished via telehealth, an eligible provider may select the appropriate code based on medical decision-making or time (i.e., the total time associated with the E/M on the day of the encounter). In these cases, the eligible provider does not need to document history and/or physical exam in the patient's record. CMS notes this policy is similar to the one that will apply to all office/outpatient E/M visits beginning in 2021 under rules finalized in the 2020 Medicare Physician Fee Schedule Final Rule.

CPT Code	Total Minutes
99201	17
99202	22
99203	29
99204	45
99205	67
99211	7
99212	16
99213	23
99214	40
99215	55

An eligible provider should submit claims for telehealth services to the same Medicare Administrative Contractor (MAC) to which the eligible provider submits claims for face-to-face services, even if the telehealth patient is present in a different MAC's jurisdiction.

In a recent FAQ, CMS advised that eligible providers who furnish telehealth services from their homes are "not required to update their Medicare enrollment with the home location. The [eligible provider] should list the home address on the claim to identify where the services were rendered. The discrepancy between the practice location in the Medicare enrollment (clinic/group practice) and the practice location identified on the claim (provider's home location) will not be an issue for claims payment."

CMS in the IFR clarified that if the patient is present in a healthcare facility when receiving telehealth services (e.g., a skilled nursing facility), that facility may bill Medicare an originating site fee, even if the site is not located in a rural area. This is a change in policy, as CMS has not permitted non-rural sites to bill this fee in other circumstances in which the telehealth geography and location restrictions have been waived (e.g., telestroke). Instructions for billing the originating site fee are available on MAC websites.

Deductibles and coinsurance apply to telehealth services. However, the HHS Office of Inspector General (OIG) is providing flexibility for eligible providers to reduce or waive beneficiary cost-sharing for these services during the PHE.

Telehealth Billing for RHCs and FQHCs

On April 17, the Centers for Medicare & Medicaid Services (CMS) published a MLN Matters® Special Edition Article on telehealth billing for rural health clinics (RHCs) and federally qualified health centers (FQHCs) during the COVID-19 PHE.

Prior to the passage of the CARES Act on March 27, there was no legislative authority for CMS to pay Clinics for telehealth services. Section 1834(m) of the Social Security Act, the provision that defines the Medicare telehealth benefit, only provides coverage for services furnished under the Medicare Physician Fee Schedule (MPFS).

Section 3704 of the CARES Act now authorizes RHCs and FQHCs to furnish telehealth services to Medicare beneficiaries for the duration of the COVID-19 PHE. Congress directed CMS to develop payment rates for these services that are similar to the national average payment rates for comparable telehealth services under the MPFS.

According to the MLN Article, RHCs and FQHCs will be paid different rates for telehealth services furnished before July 1, 2020, and after that date:

For telehealth distant site services furnished between January 27, 2020, and June 30, 2020, [Clinics] must put Modifier "95" (Synchronous Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System) on the claim. RHCs will be paid at their all-inclusive rate (AIR), and FQHCs will be paid based on the FQHC Prospective Payment System (PPS) rate. These claims will be automatically reprocessed in July when the Medicare claims processing system is updated with the new payment rate. RHCs and FQHCs do not need to resubmit these claims for the payment adjustment.

For telehealth services furnished on or after July 1 through the end of the COVID-19 PHE, RHCs and FQHCs are directed to use a Clinic-specific G code, G2025, to identify services that were furnished via telehealth. These claims will be paid $92, which is the average amount for all MPFS telehealth services on the telehealth list, weighted by volume for those services reported under the MPFS. This amount will be updated if the COVID-19 PHE continues into 2021.

Although the costs for furnishing telehealth services will not be used to determine the RHC AIR or the FQHC PPS rates, these costs must be reported on the appropriate cost report form:

RHCs must report both originating and distant site telehealth costs on Form CMS-222-17 on line 79 of the Worksheet A, in the section titled “Cost Other Than RHC Services.” FQHCs must report both originating and distant site telehealth costs on Form CMS-224-14, the Federally Qualified Health Center Cost Report, on line 66 of the Worksheet A, in the section titled “Other FQHC Services”. Since telehealth distant site services are not paid under the RHC AIR or the FQHC PPS, the Medicare Advantage wrap-around payment does not apply to these services. Wrap-around payment for distant site telehealth services will be adjusted by the MA plans.

Medicare Coverage for Communication Technology-Based Services

In the last few years, CMS has expanded coverage for several communication technology-based services (CTBSs). Although CTBSs are not furnished face-to-face, CMS does not consider these services to be subject to the restrictions in Section 1834(m). While telehealth services are a substitute for a face-to-face interaction, CTBSs are defined by the use of technology.

CMS has relaxed or clarified the rules regarding several CTBSs—including virtual check-ins, e-Visits, and remote patient monitoring—to afford providers more options to care for patients during the PHE.

Virtual Check-Ins. While telephone-only patient interactions do not qualify as telehealth services, they may be reimbursed as virtual check-ins under HCPCS G2012 if specific requirements are satisfied. Medicare pays approximately $15 for HCPCS G2012.

In a March 17 fact sheet, CMS advised as follows:

Medicare pays for these “virtual check-ins” …for patients to communicate with their doctors and avoid unnecessary trips to the doctor’s office. These virtual check-ins are for patients with an established (or existing) relationship with a physician or certain practitioners where the communication is not related to a medical visit within the previous 7 days and does not lead to a medical visit within the next 24 hours (or soonest appointment available). The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would generally apply to these services.

Doctors and certain practitioners may bill for these virtual check-in services furnished through several communication technology modalities, such as telephone (HCPCS code G2012). The practitioner may respond to the patient’s concern by telephone, audio/video, secure text messaging, email, or use of a patient portal. Standard Part B cost sharing applies to both.

In the IFR, CMS made two changes to these billing rules for virtual check-ins for the duration of the PHE. First, virtual services may be furnished to new patients as well as established patients.

Second, CMS noted the OIG's statement regarding reduction or waiver of beneficiary cost-sharing applies to virtual check-ins.

Also, CMS clarified that consent for virtual check-ins need only be obtained once annually, that it may be obtained at the same time that a service is furnished, and that it may be obtained by auxiliary staff under general supervision, as well as by the billing practitioner.

e-Visits. For other types of patient communications, a provider also may receive reimbursement for an e-Visit. As CMS explained in the March 17 fact sheet:

In all types of locations including the patient's home, and in all areas (not just rural), established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient. For these **E-Visits**, the patient must generate the initial inquiry and communications can occur over a 7-day period. The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable. The patient must verbally consent to receive virtual check-in services. The Medicare coinsurance and deductible would apply to these services.

In the IFR, CMS made the same modifications to the billing rules for e-Visits as it did for virtual check-ins regarding new patients, waiver of beneficiary cost-sharing, and consent.

CMS began reimbursing eVisits effective January 1, 2020. CMS requires the service be provided to patients via a HIPAA-compliant platform, such as an electronic health record portal, secure email, or other digital application. The level of service is based on the cumulative number of minutes the billing practitioner spends with the patient over a seven-day period (clinical staff time cannot be counted):

CPT Code	Cumulative Time (over 7-day period)	Non-Facility	Facility
CPT 99421	5-10 minutes	$15.52	$13.35
CPT 99422	11-20	$31.04	$27.43
CPT 99423	21 or more	$50.16	$43.67

E-Visits performed by qualified non-physician healthcare professionals are billed using the following codes:

HCPCS Code	Cumulative Time (over 7-day period)	Facility and Non-Facility
G2061	5-10 minutes	$12.27
G2062	11-20	$21.65
G2063	21 or more	$33.92

CMS explained in the IFR that these codes may be billed "as licensed clinical social worker services, clinical psychologist services, physical therapist services, occupational therapist services, or speech language pathologist services, so practitioners that report services in those benefit categories could also report these online assessment and management services."

Unlike telehealth services, CMS does allow RHCs and FQHCs to participate in eVisits. In the IFR, CMS extended reimbursement for eVisits to RHCs and FQHCs under HCPCS G0071, with a payment rate of $24.76.

Remote Patient Monitoring. In 2019, CMS began reimbursing practitioners for remote patient monitoring (RPM) services furnished to patients with chronic conditions. PYA's white paper, Providing and Billing Medicare for Remote Patient Monitoring, details the opportunity presented by this new reimbursement.

In the IFR, CMS clarified the rules regarding RPM, both during the PHE ***and beyond***:

RPM codes can be used for physiologic monitoring of patients with acute and/or chronic conditions. The typical patient needing RPM services may have a chronic condition (for example, high blood pressure, diabetes, COPD). However, RPM can be used for other conditions. For example, RPM services allow a patient with an acute respiratory virus to monitor pulse and oxygen saturation levels using pulse oximetry. Nurses, working with physicians, can check-in with the patient and then using patient data, determine whether home treatment is safe, all the while reducing exposure risk and eliminating potentially unnecessary emergency department and hospital visits.

As with other virtual services, the IFR clarifies that the OIG's statement regarding reduction or waiver of beneficiary cost-sharing applies to RPM services and relaxes the rules regarding consent for these services for the duration of the PHE for the COVID-19 pandemic.

Telephone E/M Services

For years, CMS refused to reimburse for telephone E/M services, claiming such telephone calls were reimbursed as part of other face-to-face interactions. In the IFR, however, CMS announced Medicare would, for the balance of the PHE for the COVID-19 pandemic, reimburse the following telephone E/M services for new and established patients at the following national payment rates:

CPT	Description	Non-Facility	Facility
99441	Telephone evaluation and management service by a **physician or other qualified health care professional who may report E/M services** provided to established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$14.44	$13.35
99442	Same, 11-20 minutes of medical discussion	$28.15	$26.71
99443	Same, 21-30 minutes of medical discussion	$41.14	$39.70
98966	Telephone assessment and management service provided by **qualified nonphysician health care professional** to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$14.44	$13.35
98967	Same, 11-20 minutes of medical discussion	$28.15	$26.71
98968	Same, 21-30 minutes of medical discussion	$41.14	$39.70

Regarding CPT 98966 – 98968, CMS noted “that these services may be furnished by, among others, LCSWs, clinical psychologists, and physical therapists, occupational therapists, and speech language pathologists when the visit pertains to a service that falls within the benefit category of those practitioners.” Also, to facilitate billing by therapists, CMS designated these codes as “sometimes therapy” services, thus requiring the private practice occupational therapist, physical therapist, and speech-language pathologist to include the corresponding GO, GP, or GN therapy modifier on claims for these services.

RHC and FQHC Payment for Telephone-Only Services

Also in the April 17 MLN Article, CMS clarified that RHCs and FQHCs will be reimbursed for telephone-only services – including virtual check-ins (HCPCS G2012) and telephone evaluation and management services (CPT 99441-99442) - under G0071. Unfortunately, CMS still will not permit RHCs and FQHCs to bill for remote patient monitoring.

Effective March 1 and continuing for the duration of the COVID-19 PHE, the payment for G0071 will be $24.76, instead of the CY 2020 rate of $13.53. Medicare Administrative Contractors will automatically reprocess any claims with G0071 for services furnished on or after March 1 that were paid before the claims processing system was updated.

Kansas Policy Primer *(Updated 4-27-20 – see updates in blue)*

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A Provider's Guide:
Telehealth Requirements and Policy Changes in Kansas During COVID-19

Rapid developments with the COVID-19 pandemic have resulted in a set of broad expansions of telehealth policy, including key changes to both public and private payer payment policies, at least for the duration of this emergency period. This guide is meant to help healthcare providers and organizations get up to speed quickly on these changes and key components of telehealth payment in Kansas. Please keep in mind that events and policies are changing rapidly, and that this document will be updated frequently as new information and policies become available/are enacted.

Governor's Executive Orders

Telehealth-Executive Order 20-08

Governor Kelly has instituted a number of executive orders, including one that specifically modifies requirements on telehealth services and licensure to promote sustained access to healthcare services via telehealth for individuals in Kansas during this unprecedented pandemic (Executive Order 20-08, https://governor.kansas.gov/wp-content/uploads/2020/03/E.O.-20-08.pdf).

Executive Order 20-08 both allows and encourages physicians to provide services through telemedicine. Physicians are still required to provide an appropriate assessment and consultation including documentation and encouraged to consult the Kansas Prescription Drug Monitoring Program (K-TRACS) before providing a prescription for a controlled substance. The specific changes in Kansas during the period of the public health emergency that impact the delivery of telehealth services are summarized below:

1. An in-person examination in order to provide a prescription or order medication, including controlled substances, is not required.
2. Physicians who are not physically located in Kansas may provide care in Kansas through telemedicine or other means as long as they inform the Kansas Board of Healing Arts and have an unrestricted license to practice in any other state without a current investigation or disciplinary hearing.
3. The Board of Healing Arts may provide emergency licensure to those professions it regulates in order to respond to COVID-19.

Kansas Medicaid (KanCare) and the Managed Care Organizations are in the process of adopting policies and procedures to reflect this Executive Order and other guidance. Please see the Table

at the end of this document for an overview of recommendations and changes to requirements with links to documents and guidance from relevant state entities (KDHE, KDADS, Licensure Boards).

Please Note that information and application materials for providers seeking temporary or expedited emergency licenses and for out-of-state providers who need to inform the board that they are practicing telemedicine in Kansas in accordance with E.O. 20-08 are available on the Kansas Board of Healing Arts website.

Executive Order 20-08 only applies to those professions licensed by the Board of Healing Arts, and does not apply to the Board of Nursing, Behavioral Health Sciences Regulatory Board or other state licensure entities. Please see more information about Licensure Board Actions and Accommodations provided later in this document.

Professional and Occupational Licenses-Executive Order 20-19

Executive Order 20-19 requires all state agencies to extend renewal deadlines for any occupational or professional license, certificate, permit, or registration issued by a state agency or any board, commission, division, or other licensing authority within a state agency to any individual, business, or organization that was in good standing as of March 12, 2020 that has expired or will expire during the public health emergency and extends these licenses until 90 days following the termination of the emergency declaration. This order does not apply to driver's licenses or vehicle registration and regulation, which is covered under Executive Order 20-12. This order also does not apply to attorneys. All stage agencies must waive late, delinquent, penalty, or expiration fees associated with these licenses or registrations.

In addition, all state agencies must extend the deadlines for mandated continuing education requirements until 90 days following the termination of the emergency.
https://governor.kansas.gov/executive-order-no-20-19/

Licensure, Registration, and Certification-Executive Order 20-23

Executive Order 20-23 extends the provisions of Executive Order 20-19 to all state agencies that work with or collaborate with the Kansas Department for Aging and Disability Services (KDADS) for occupational or professional license, certificate, or registration issued by a state entity. It allows for temporary licensure, certificate, or registration for any persons previously licensed, certified, or registration offered by a state entity as long as the individual was in good standing prior to the lapse of that license and the license did not lapse more than five years prior to the date of the order (April 15, 2020). It allows for temporary aide authorization to individuals who receive minimum training in a nursing facility as set forth by KDADS with requirement set forth in the Executive Order. In addition, temporary authorization may be issued to individuals not previously licensed, but only for those working with individuals who require minimal supervision or assistance with activities of daily living, and as long as facilities ensure competence.

The Executive Order also provides for the extension of licensure for adult care homes for inspections for new or renewal KDADS licensed facilities until 90 days after the termination of the state disaster emergency, and the suspension of fees for licensure or increases in bed capacity, along with other modifications to requirements for adult care homes.

Extension of Public Health Emergency-Executive Order 20-24

On April 16, Governor Kelly implemented Executive Order 20-24, extending Executive Order 20-16—Establishing a state-wide "stay home" order until May 3, 2020 or until the statewide State of Disaster Emergency proclaimed on March 12, 2020 expires, whichever is earlier.

Relief from Certain Restrictions and Requirements Governing Medical Services-Executive Order 20-26 (Updated 4-23-20)

On April 22, 2020, Governor Kelly implemented Executive Order 20-26, which suspends any and all provisions in statute relating to supervision, delegation, and related issues by and to health care providers that are licensed, registered or certified and for ancillary workers to the extent necessary to allow licensed, registered, or certified health care professionals to provide, within a designated health care facility at which the professional is employed or contracted to work, medical services necessary to support the facility's response to the public health emergency and that are appropriate to the professional's education, training, and experience as determined by the facility in consultation with the facility's medical leadership. Please read the order in its entirety for detailed information about these complex and substantial changes: https://governor.kansas.gov/executive-order-no-20-26/.

Under this order, medical services may be provided without supervision from a licensed physician or nurse, without criminal, civil, or administrative penalty related to the lack of supervision or lack of a supervision agreement. Specific statutory requirements suspended include those related to supervision, delegation, and related issues to the extent necessary to permit:

- Physicians assistants to provide services without a written practice agreement with a physician;
- Advanced practice registered nurses, including nurse anesthetists, to provide services without a written collaborative agreement and without physician supervision or direction;
- Registered Nurses and Licensed Practical Nurses for supervision, delegation, and related issues in order to collect throat or nasopharyngeal swab specimens for individuals suspected of being infected by COVID-19 for testing;
- Licensed Practical Nurses to provide medical services without registered nurse supervision;
- Licensed Pharmacists to provide care for routine health maintenance, chronic disease states, or similar conditions without physician supervision;
- Registered nurses with an exempt, inactive, or lapsed (within the last five years) license to provide medical services.

There is no change to the requirements for health care professionals for whom a license is unnecessary for their level of practice.

In addition, health care facilities, in order to support their response to COVID-19, are temporarily authorized to allow:

- Students who are enrolled in programs to become licensed, registered, or certified health care professionals to volunteer or work in the facility;
- Licensed, registered, or certified health care professionals and emergency medical personnel serving in the military in any duty status to volunteer or work in the facility;

- Medical students, physical therapists, and emergency medical personnel to work as "respiratory extenders" under the supervision of physicians, respiratory therapists, or advanced practice registered nurses, in order to assist respiratory therapists and other health care professionals in the operation of ventilators or related devices.
  - In addition, this group may provide other services necessary for the facility's response to COVID-19.

The order also allows health care professionals licensed and in good standing in another state or territory of the U.S. to practice in Kansas. Any limits that a provider has on their license in their state of licensure is subject to the same limitation while practicing in Kansas.

In addition, health care facilities are temporarily authorized to use qualified volunteers or qualified personnel affiliated with other health care facilities as if the individual was an employee of their own facility (with potential terms or conditions to be set by the Secretary of the Kansas Department of Health and Environment).

All health care providers, including those in the definition for this term in KSA 40-3401, and also RNs, APRNs, LPNs, Pharmacists, unlicensed volunteers, military personnel, or students and other support personnel, and all entities listed in KSA 48-915, who are making clinical and triage decisions and rendering assistance, testing, care, or advice in the care of patients suspected or confirmed to be infected with COVID-19, and rendered in response to public health emergency, shall be deemed immune from suit unless it is determined that an act occurred involving willful misconduct, gross negligence, recklessness, or bad faith on the part of the facility or health care provider.

Health care professionals with a license that has lapsed within the last five years, are not required to take an exam to regain licensure not available during the emergency, be fingerprinted if unavailable during the emergency, receive required continuing education, or pay a fee to retain licensure for the period of the public health emergency. In addition, all professional certifications in basic life support, advanced cardiac life support, or first aid will not lapse during the emergency period. Fingerprint requirements for licensure or certification for hospitals, nursing homes, county medical care facilities, or psychiatric hospitals are also suspended.

Center for Medicare and Medicaid Services (CMS) Section 1135 Waiver

On March 24, 2020, CMS approved a waiver of requirements for the state Medicaid program (including the Children's Health Insurance Program) for Kansas. https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/?entry=54054. Changes that impact the delivery of telehealth services are outlined below:

1. Allows Kansas to temporarily suspend prior authorization requirements and extend pre-existing prior authorizations for enrollees.
2. Allows Kansas to temporarily provisionally enroll providers in the state Medicaid program who are enrolled in another state or with Medicare for multiple instances of care with multiple patients.
   a. Allows Kansas to enroll providers not enrolled in another state or with Medicare without requiring an application fee, criminal background check, site visit, or Kansas license.

   b. Also allows Kansas to temporarily cease the revalidation of providers currently enrolled in the program.

3. Extends timeline for fair hearing appeals processes.

Kansas Medicaid Assistance Program (KMAP)

General guidelines related to the provision of telehealth services are available in KMAP Bulletin 18224 available on the KMAP website at: https://www.kmap-state-ks.us/Documents/Content/Bulletins/18224%20-%20General%20-%20Telemedicine_2.pdf.

Many rules and regulations related to the provision of telehealth services have changed for the period of the COVID-19 emergency declaration. KMAP has created provider information with updated information related to COVID-19 policies on its website at: https://www.kmap-state-ks.us/. In addition, all provider bulletins are available at: https://www.kmap-state-ks.us/Public/bulletins/bulletinsearch.asp.

Additional Information Related to Telehealth Provision of Services—Bulletin 20045

On March 23, Adam Proffitt, state Medicaid Director, stated in Bulletin 20045, "The reimbursement rates for distant sites for services delivered through telemed will be equivalent to identical services provided in person. The Medicaid fee-for-service fee schedule that is posted on the KMAP website will serve as the source of truth for reimbursement by code. There will be no change in reimbursement level for existing originating sites. In the instances that "home" is the originating site, then there will be no originating site fee paid for that claim."

Telehealth Updates in Response to COVID-19—Bulletin 20046

On March 31, 2020, Kansas Medicaid released KMAP General Bulletin 20046. Effective with dates of service on or after March 12, 2020, the bulletin details codes will be allowed for payment when provided by telemedicine/telephone. Providers will be allowed to be reimbursed for the codes when the originating Telemedicine site is place of service "home" (POS code 12).

- Please note that all services provided by telemedicine/telephone will need to be billed with POS code 02 (not 12).
- Only those services directly provided face-to-face by a provider in the home are eligible for POS code 12.

Telemedicine services (including telephonic contact) can be made when there is verbal consent received from the patient (to be followed up by written approval) in the medical record. Please note: Tele-video communication can only be utilized if that system is HIPAA compliant.

- Mental Health Codes: 90832-34, 90836, 90838-40, 90847, 90863, H0036 (with all current modifiers allowed), H0038, H0038HQ, 90792.
- SUD Codes: H0001, H0004, H0005 U5, H0006 U5, H0015 U5, H0038, H0038 HQ.
- SBIRT Codes: H0049, H0050, 99408, 99409
- Evaluation and Management: 99201-203, 99211-213

For the following codes for Autism services, telephone coverage is not allowed: 97155, 97156.

For Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), or Indian Health Clinic (IHC), these entities will receive an encounter rate when serving as the distant site.

In addition, nursing facilities may serve as an originating site using the billing code of Q3014, with requirements outlined in KMAP Bulletin 18224 continuing to be in effect.

Please note:

- The code G2012, Virtual Check In, is not allowed.
- Out of state physicians may provide services through telehealth without a Kansas license as long as they are licensed in the state where they practice, but this does not extend to any other provider type.
- While these changes went into effect on March 12, that may not be the date that the MCO begins covering/reimbursing for these services. MCO system status for implementation is available on the KMAP bulletins page.

One Care Kansas-Bulletin 20047

Effective April 1, 2020 and through the duration of the public health emergency, to help facilitate social distancing for OneCare Kansas (OCK) partners and members, the following changes will be made to OCK service requirements:

- The initial OCK Health Action Plan (HAP) completion, consent to treat and share information, and all OCK core services, can be done telephonically. OCK billing codes provided telephonically need to bill in a POS 02. Verbal consent and agreement can take the place of the member's signature where normally required.
- Compliance with the above guidance will not pose a barrier to payment.
- Managed Care Organization (MCO)s and the State shall hold the OCK partners harmless during this public health emergency period.

Home and Community Based Services-Bulletin 20051

Home and Community Based Service providers are allowed to provide services through telemedicine, effective March 12, including services to the home through telephone or HIPAA-compliant tele-video. This bulletin includes allowed service codes and whether they can be provided through televideo or telephone for brain injury, physical disability, autism, frail elderly, technologically assisted, I/DD, and Severe and Emotionally Disturbed Waivers. Please see Bulletin 20051 available on the KMAP website 200for a list of allowed codes by waiver type.

Teledental-Bulletin 20052

Effective March 12, KMAP will reimburse for the provision of limited teledental services. All provided services must be provided by providers appropriate to the services and will be reimbursed the same as face to face services. Requirements for in-person face-to-face visits are being waived during the emergency declaration. FQHCs and RHCs will receive an encounter rate when serving as the distant site and all televideo communication methods must be HIPAA-compliant. The allowed codes are: D0140, Limited Oral Evaluation-Problem Focused, and D0170, Re-Evaluation-Limited, Problem Focused (Established Patient, not Post-Operative).

Reversal of Sequestration Reduction to RHCs, FQHCs, and IHCs-Bulletin 20054

Effective retroactive to service dates on and after July 1, 2019, the State of Kansas/Manage Care Organization (MCO)s are responsible for the full encounter rate per the state plan amendment for Rural Health Clinic (RHC)s, Federally Qualified Health Center (FQHC)s and Indian Health Center (IHC)s. Impacted claims will be reprocessed.

Managed Care Organization Out of Network Provider Information-Bulletin 20057

During the COVID-19 Emergency Declaration period, services provided by temporary non-network providers will be allowed and will be reimbursed at the same rate as a participating provider. All existing Medicaid coverage and licensing requirements apply unless otherwise noted in a related COVID-19 publication. **All current Managed Care Organization (MCO) prior authorization (PA) out-of-network requirements will remain in effect.** The MCOs will, at a minimum, collect the TIN (SSN or EIN) and applicable state licensure and any other information needed for claim processing, and ensure the practitioner is not OIG excluded prior to paying the claim. MCO non-network providers are not required to enroll in the Kansas Medical Assistance Program (KMAP) to provide services to MCO members.

Out-of-state physicians may provide telemedicine when treating patients in Kansas without a Kansas license, provided the physician hold an unrestricted license in the state in which the physician practices. This does not extend to any other licensed provider.

Please note: Out of state physicians must submit the appropriate form notifying the Kansas Board of Healing Arts that they are practicing through telemedicine in Kansas using the form available at: http://www.ksbha.org/main.shtml.

Early Childhood Intervention (ECI) and Local Education Agency (LEA) providers—Bulletin 20062

Effective March 12, 2020, Early Childhood Intervention (ECI) and Local Education Agency (LEA) providers will be allowed to provide the following services using telephone or telehealth that previously were only allowed in-person:

- Early Childhood Intervention—T1001, T1017, T1027, 99402, 99404;
- Local Education Agency—T1001, 99402.

Audiology and Speech Language Pathology will continue to be allowed to be provided via telemedicine and is not changed with this policy. Reimbursement will be the same as a face-to-face visit. Services provided by telemedicine/telephone will need to be billed with POS code 02.

Additional Codes Added to Telemedicine—Bulletin 20065

In addition to those codes outlined in Bulletin 20046, additional behavioral health codes were added with an effective date of March 12, 2020. Telehealth services (including telephone without video) can be made with verbal consent with follow-up written consent obtained. Allowed provider types and specialties remain unchanged. Reimbursement is the same as a face-to-face visit. Treatment plans should be updated to correspond with the change in service delivery mode. The following providers are allowed to be reimbursed for the following codes when the originating telehealth site is the member's home:

- Substance Abuse Disorder Providers: H007.
- Mental Health Providers: 90791, 90792, 90853, 99367, 99368, H0032 HA, H2011 HO, H2017, H2017 HQ, H2017 TJ, T1019 HE.

No payment for Q3014 will be made for place of service 12 (home) without the physical presence of an enrolled provider. All services provided through telehealth or telephone should use place of service 02.

Tobacco Cessation-Bulletin 20067

Effective March 12, 2020, tobacco cessation counseling will be allowed through telehealth. This policy only allows for an additional delivery method. Allowed provider types and specialties will remain unchanged. Telemedicine services (including telephonic contact) can be made when there is verbal consent received from the participant (to be followed up by written approval) in the medical record. Tele-video communication can only be utilized if that contact is HIPAA compliant. Reimbursement will be the same as a face-to-face visit. The appropriate codes are 99406, 99407 and S9453.

Brain Injury (BI) Waiver Services-Bulletin 20068

Effective March 12, 2020, the following Home and Community Based Services (HCBS) waiver services will be allowed to be provided via telemedicine (and additionally by telephone for Speech-Language Therapy). Providers will be allowed to be reimbursed for the following codes when the originating telemedicine site is in the member's home. No payment for the Q3014 code will be made for POS 12 (home) without the physical presence of an enrolled provider. Verbal consent is allowed to be followed up by written approval in the medical record. Reimbursement will be the same as a face-to-face visit. Services allowed are: Occupational Therapy-G0152 (televideo only); Physical Therapy-G0151 (televideo only); Speech-Language Therapy-G0153 (televideo and telephone allowed).

Serious Emotional Disturbance (SED) Waiver Codes-Bulletin 20070

The following codes are now allowed for telehealth and telephone services for providers of services SED Waiver services: T1019HK, T2038, S5110, S5110 TJ, H2021.

COVID-19 Public Health Emergency Temporary Waivers-Bulletin 20071

During March and April 2020, CMS has approved waivers or modifications of federal Medicaid requirements to ensure that sufficient health care services are available to beneficiaries, to ensure reimbursement to providers for healthcare services, and to preserve appeal and fair hearing rights. Detailed information on these federal waivers and accommodations is available in HTRC's Federal Policy Document available on the website. The waivers and modifications affect prior authorization requirements for health care services, MCO appeal timelines, and state fair hearing timelines as noted below.

<u>Prior Authorizations:</u>

- <u>Fee-for-Service (FFS) Beneficiaries:</u> CMS approved a temporary waiver that will allow a suspension of prior authorization requirements for FFS beneficiaries retroactive to March 1,

2020 until the end of the federally declared public health emergency. The State will waive the requirement to obtain prior authorization for FFS services that began March 1, 2020 or after until the end of the federally declared public health emergency.

- FFS Beneficiaries and Managed Care Members: CMS approved a temporary waiver that will allow an extension of pre-existing authorizations for which a FFS beneficiary or managed care member had received prior authorization for services to be provided on or after March1, 2020. The extension will allow for continuation of those services without a requirement for a new or renewed prior authorization through the end of the federally declared public health emergency. The State will implement this temporary extension, which will supersede the current continuation of service process during an appeal or fair hearing, until the end of the federally declared public health emergency.

Member Appeals and State Fair Hearings CMS approved a temporary waiver that will allow modification of the timeframe for MCOs to resolve member appeals before a member may request a state fair hearing; CMS approved a temporary waiver that will allow modification of the timeframe for members to exercise their state fair hearing rights.

FFS/Managed Care Provider Appeals and State Fair Hearings: CMS approved a temporary waiving or modifying of certain requirements to ensure that health care providers who furnish items and services in good faith, but are unable to comply with one or more requirements as a result of the COVID-19 public health emergency, are reimbursed for those items and services and exempted from sanctions for noncompliance. The state is allowing additional timeframes for state fair hearings, appeals and external third-party reviews for fee for service and managed care providers if the deadline falls during the public health emergency.

Details of the guidelines for appeals and fair hearings are available in this Bulletin on the KMAP website in Bulletin 20071.

Additional E/M Codes Allowed—Bulletin 20072

Effective March 12, the codes of 99204 and 99214 will be allowed when the originating telehealth site is the member's home, including the use of telephone without video capacity. No payment for Q3014 will be made for place of service 12 unless the provider is physically present in the home. Place of service 02 should be used for telehealth and telephone services. Verbal consent must be sought followed by written consent in the medical record. All telehealth (audio/video) must be HIPAA compliant.

KMAP has created provider information with updated information related to COVID-19 policies on its website at: https://www.kmap-state-ks.us/. In addition, all provider bulletins discussed above along with any new bulletins are available at: https://www.kmap-state-ks.us/Public/bulletins/bulletinsearch.asp.

Expansion of Telemedicine for Therapy-Bulletin 20073 (Updated 4/23/20)

Effective March 12 and until the end of the public health emergency, the following codes are allowed for payment related to therapy (not behavioral health) with allowed provider types unchanged when provided to the patient's home only through televideo (audio and video): 97110, 97112, 97140, 97161-68, 97530, 97535, 97750. The following codes are allowed for payment for

either telephone (audio-only) or televideo (audio and video): 92521-24. Verbal consent followed by written consent in the medical record is required, and all televideo (audio and video) must use a HIPAA-compliant platform.

COVID-19 Claims Reimbursement for Testing and Treatment-Bulletin 20088 (Updated 4/27/20)

As part of the Families First Coronavirus Response Act (FFCRA) and CARES Act, the U.S. Department of Health and Human Services (HHS), will provide claims reimbursement to health care providers generally at Medicare rates for testing uninsured patients for COVID-19 and treating uninsured patients with a COVID-19 diagnosis. Effective Monday, April 27, 2020, providers may begin the enrollment process with the Health Resources and Services Administration (HRSA) to receive reimbursement for the uninsured population. This includes the spenddown population that has not reached their spenddown to become Medicaid eligible. Health care providers who have conducted COVID-19 testing or provided treatment for uninsured COVID-19 patients on or after February 4, 2020, can request claims reimbursement through the HRSA program electronically and will be reimbursed generally at Medicare rates, subject to available funding.

Kansas Department of Aging and Disability Services (KDADS)

The state of Kansas submitted a waiver application for home and community-based services under Section 1912(c) through an Appendix K document. A copy of the approved Appendix K waiver is available on the KDADS website at: https://www.kdads.ks.gov/covid-19 and on the CMS website at: https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/home-community-based-services-public-heath-emergencies/emergency-preparedness-and-response-for-home-and-community-based-hcbs-1915c-waivers/index.html.

KDADS has also provided specific guidance related to COVID-19 regulation and rule changes on its website at: https://www.kdads.ks.gov/covid-19. Specific guidance related to the provision of telehealth services is described below:

Home and Community Based (HCBS) Waiver Programs

In a bulletin dated April 14, KDADS indicated that for all HCBS waivers, services that can be provided through telehealth as approved by KDADS may be completed using telecommunications (phone), televideo consultations/telemedicine or other HIPAA-complaint methods that include both audio and video. Details of assessments and other activities for specific waivers and population that may be conducted using telehealth are available in individual documents related to the waiver or population, with an overview provided in the bulletin: "HCBS Waiver Services with Approved Telemedicine Option," available on the KDADS website at: https://www.kdads.ks.gov/covid-19.

Substance Use Providers*:* KDADS provided guidelines for expanded substance use services for substance use providers that took effect March 23. It expands the allowable services for telephonic and telemedicine to be delivered in the home of patients. The guidance requires Medicaid Managed Care Organizations and the Administrative System Organization to pay for these services at the same rate as if delivered face-to-face.

The following SUD services by fee code are approved for telephonic delivery in the home for Kansas Block Grant and DUI Providers: H0001 GT, H0004 GT, H0005 U5/GT, H0006 U5/GT,

H0006 U5/HV/GT, H0007 GT, H0015 U5, H0015 U5/HA, H0038 GT/HF Individual, H0038 GT/HQ/HF Group.

The following SUD services by billing code are approved by KDHE for telephonic delivery in the home for KanCare SUD: H0001, H0004, H0005 U5, H0006 U5, H0015 U5, H0038, H0038 HQ.

Kansas Department of Health and Environment (KDHE)

KDHE is the main coordinating agency for the COVID-19 response, and has created a health care provider website available at: https://www.coronavirus.kdheks.gov/170/Healthcare-Providers. The site contains clinical and other information for: Hospitals, Health Departments, Labs, Outpatient Clinics, PPE, Specimen Collection, and Testing.

Kansas Board of Healing Arts

The Board of Healing Arts has not provided any new information on its website that reflect changes related to Executive Order 20-26 as of April 27, 2020.

Previously, they released a memorandum available on their website with emergency actions and guidance:
http://www.ksbha.org/documents/misc/Guidance_for_Healthcare_Professionals_in_Kansas.pdf.
The memo outlines actions the board has taken to contribute to the capacity of our state's healthcare system to respond to potential spikes in the numbers of patients seeking access to treatment related to COVID-19. These include:

- A new temporary emergency license process for physicians willing to provide COVID-19 related care to Kansas patients along with a previously established expedited licensing ability for professions overseen by the Board;
- A waiver process implementing expanded telemedicine options pursuant to Governor Laura Kelly's March 22nd Executive Order 20-08 (requiring the notification of the board by the physician as outlined above);
- Temporary waiver of Board Enforcement of most statutes, rules or regulations that require in-person examination of a patient prior to prescribing medication;
- Temporary modification to regulations relating to Physician Assistant practice, including modifications to supervision requirements;
- Board guidance statements relating to licensee's practice during the emergency declaration period.

Kansas State Board of Nursing ***(Updated 4-27-20)***

The Board of Nursing has provided a synopsis of how Executive Order 20-26 impacts licensure and other components of practice for those professions it oversees available at: https://ksbn.kansas.gov/wp-content/uploads/2020/04/Executive-Order-No.-20-26-4-22-2020.pdf.

Please note that in this memo, the Board of Nursing clarifies that, "Nurses who hold a license that is exempt, inactive, or has lapsed within the past five (5) years must apply for a Temporary Emergency COVID-19 license that will expire when this Executive Order expires. If the nurse wants to reinstate their license after the Temporary Emergency COVID-19 license expires they will need to reinstate the license the normal way with the requirements of continuing education and a fee."

The Board also clarifies that, "Nurses licensed in other states coming into Kansas to help with the COVID-19 pandemic do not need to do anything with the Kansas State Board of Nursing. It is the responsibility of the employer to verify their license is in good standing."

Behavioral Health Sciences Regulatory Board
Executive Order 20-26 does not appear to impact those professions licensed by the Behavioral Sciences Regulatory Board.

The Behavioral Sciences Regulatory Board has placed a notice on their website that teletherapy services count toward the 1500 required hours of direct client contact for clinical licensure for Addiction Counseling, Marriage and Family Therapy, Master's Level Psychology, Professional Counseling, or Social Work —but not telephonic services (https://ksbsrb.ks.gov/).

In addition, the BSRB has provided an update memo related to telebehavioral health services available at: https://ksbsrb.ks.gov/docs/default-source/default-document-library/important-information-regarding-telemental-health1665e446357f69b7acc5ff0000cef974.pdf?sfvrsn=da1a8d85_0. In this memo, they note that the Board does not have the authority to allow exceptions to the current statutes and regulations concerning teletherapy services, as the agency has not been given authority by the legislative or executive branch of Kansas government to make any type of exception. This includes out of state providers providing care in Kansas, although it is possible to obtain temporary licensure, with links to the forms available in the memo (link above).

Please note, though, that there have been additional codes and other accommodations made to foster the provision of telebehavioral health services at the federal and state level. Federal changes made by CMS and others are detailed in the federal policy document available on the HTRC website, and additional codes and changes in Kansas are detailed below in sections related to KMAP (KanCare) and KDADS.

Kansas Dental Board
Executive Order 20-26 does not appear to impact those professions licensed by the Dental Board.

The Kansas Dental Board has provided guidance, in collaboration with KDHE, in a series of guidance documents. There are two memorandums in force currently **are KDHE Memorandum #4** which is an updated guidance document to align with the Governor's Executive Order 20-16 (temporary, statewide stay-home order), which is currently in effect until midnight on Sunday, May 3, 2020, and includes any extensions of that Executive Order. This document updates all prior guidance documents and should be implemented accordingly. In addition, KDHE Memorandum #3 from the Bureau of Oral Health (KDHE), provides guidance on "Coronavirus Disease 2019 (COVID-19) Update." KDHE Memorandums #2 and #1 are superseded by the above memorandums.

Kansas State Board of Pharmacy
The Board of Pharmacy has not provided any new information on its website that reflect changes related to Executive Order 20-26 as of April 27, 2020.

In a memorandum updated on April 14, 2020, the Pharmacy board indicated they have made the decision to temporarily allow remote work by pharmacy employees. This allowance only applies to pharmacies physically located in Kansas and persons licensed or registered with the Board. This allowance is only in effect until rescinded by the Board as published and noticed on the Board website. The Board expects nonresident pharmacies to allow remote work only in accordance with guidance issued by the governing body in the resident state. The Board has issued guidelines for pharmacies, pharmacists, technicians, and interns available at: https:/pharmacy.ks.gov/.

Kansas Insurance Department—Private Insurance

The Board of Pharmacy has not provided any new information on its website that reflect changes related to Executive Order 20-26 as of April 27, 2020.

The Kansas Insurance Department has information on their website about COVID-19. They have reached out to health insurers and learned they are implementing their contingency plans as need and are shifting employees to work from home, including claims processing and customer service. Many are also making changes to their internal policies regarding telemedicine and prescription drugs.

A memorandum on their website indicates that the Commissioner of Insurance does not have the authority to mandate expansion of telehealth services or modifications in reimbursement amounts. However, that many health insurers, but not all, are voluntarily making changes to allow telehealth services and to modify their payment practices to reimburse those services at the same level as in-person services. The Commissioner encourage everyone to check with their health insurer regarding the coverage of telehealth services. For specific information on what a health insurer is doing, please visit the health insurer's individual website. The memorandum is available at: https://insurance.ks.gov/documents/department/COVID19-FAQ.pdf The Kansas Insurance Department has provided a list of them, reproduced below for convenience:

Major Medical Insurance Companies:

Aetna Health, Inc.
www.aetna.com
Aetna Life Insurance Company
www.aetna.com
Blue Cross and Blue Shield of Kansas
www.bcbsks.com
Blue Cross and Blue Shield of Kansas City
www.bluekc.com
Cigna Health and Life Insurance Company
www.cigna.com
Coventry Health Care of Kansas
www.aetna.com
Coventry Health & Life Insurance Company
www.aetna.com
Humana Health Plan, Inc.
www.humana.com
Humana Insurance Company
www.humana.com
Medica Insurance Company

www.medica.com
Oscar Insurance Company
www.hioscar.com
Sunflower State Health Plan, Inc.
www.sunflowerhealthplan.com
UnitedHealthcare Insurance Company
www.uhc.com
Kansas State Employee Health Plan
https://admin.ks.gov/coronavirus/draw_down/sehp

Short-Term Major Medical:

Freedom Life Insurance Company of America
www.ushealthgroup.com
Golden Rule Insurance Company
www.goldenruleinsurance.com
Independence American Insurance Company
www.americanindependencecorp.com
United States Fire Insurance Company
www.cfins.com

Major Dental Insurance Companies:

Delta Dental of Kansas
https://deltadentalks.com/groups/covid-19-update

Medicaid/Managed Care

Information about policy changes related to COVID-19 is available on the KMAP website at:
https://www.kmap-state-ks.us/public/homepage.asp

Links to information from the three Managed Care Organization's response to COVID-19 are below:

Aetna
https://www.aetna.com/individuals-families/member-rights-resources/need-to-know-coronavirus.html
Sunflower Health Plan
https://www.sunflowerhealthplan.com/
United Health Care
https://www.uhc.com/health-and-wellness/health-topics/covid-19

Kansas Governmental Guidance and Requirements Summary (as of 4-14-2020)

Agency	Topics	Link
Center for Medicaid and Medicare Services	1135 Waiver approved for Kansas Medicaid Program	https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/federal-disaster-resources/?entry=54054
Kansas Office of the Governor	Executive Orders in Response to COVID-19 (EO 20-03 and subsequent); Executive Order 20-08—Expanding Telemedicine and Licensing; 20-19 Extending Licenses and Continuing Education Requirements; 20-23 Licensure, Registration, and Certification	https://governor.kansas.gov/newsroom/executive-orders/
Kansas Medical Assistance Program (KMAP)	COVID-19 Provider Information KMAP Bulletins Related to COVID-19	https://www.kmap-state-ks.us/ https://www.kmap-state-ks.us/Public/bulletins/bulletinsearch.asp
Kansas Department of Health and Environment-*COVID-19 Resource Center*	Hospitals, Health Departments, Labs, Outpatient Clinics, PPE, Specimen Collection, and Testing.	https://www.coronavirus.kdheks.gov/170/Healthcare-Providers
Kansas Department for Aging and Disability Services-*Behavioral Health Services*	Section K Appendix (Home and Community-Based 1912(c) approved CMS waiver) Behavioral Health Services; Aging, Disability Community Services and Programs, and Health Occupations	https://www.kdads.ks.gov/covid-19
Kansas Insurance Department	COVID-19 Insurance and Securities FAQs; COVID-19 Insurance and Securities Scams	https://insurance.kansas.gov/
Kansas Dental Board	KDHE Dental Memorandums	https://www.dental.ks.gov/
Kansas Board of Pharmacy	COVID-19 Pharmacy FAQ; Memorandum with Policies and Recommendations related to COVID-19	https://pharmacy.ks.gov/
Kansas Board of Healing Arts	Memo with Emergency Actions and Guidance Statements; Information on temporary and expedited licenses providers related to COVID, and information for waived physicians licensed in other states practicing telemedicine through—overview and application	http://www.ksbha.org/main.shtml
Kansas Board of Nursing	Updates and FAQ	https://ksbn.kansas.gov/covid-19/
Kansas Behavioral Health Sciences Regulatory Board	Telemental Health Provision and Emergency Licensure Application; Verification that teletherapy services count toward required hours of direct client contact for clinical for **Addiction Counseling, Marriage and Family Therapy, Master's Level Psychology, Professional Counseling, or Social Work** —but not telephonic services.	https://ksbsrb.ks.gov/docs/default-source/default-document-library/important-information-regarding-telemental-health1665e446357f69b7acc5ff0000cef974.pdf?sfvrsn=da1a8d85_0 https://ksbsrb.ks.gov/

Section 2: Fundamentals to Aid Decision-Making About Providing Care Using Telehealth

Overview

Federal and state policies relating to telehealth amidst the COVID-19 public health emergency have opened new doors for rural healthcare providers in a variety of settings. The previous section on these topics, along with the licensure, services, and billing/reimbursement details shared, lend insights to the possibilities before rural healthcare organizations.

Section 2 picks up there and helps with the next series of decisions – what your organization needs to do now to seize telehealth opportunities, and successfully plan for and implement them. The pages that follow provide a 10-step roadmap outlining the fundamentals of implementing a telehealth services delivery model, with a checklist to help keep your organization on track. There are MANY resources available with additional detail. Several you might find particularly helpful are identified within.

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Telehealth Fundamentals

Once your organization makes the decision to launch or expand on a telehealth services delivery model, there may be mounting pressure from staff and the community, as well as the spread of COVID-19, to implement quickly. Below are 10 fundamentals to consider and to guide your effort. It's more important that you consider them all reasonably well, than skip steps so you can perfect any of them. Their sequence is important because taking into account the decisions made in prior steps will help ensure subsequent ones are aligned. This improves the speed and effectiveness of your telehealth program.

1. **Define what your organization needs to accomplish now.** This will drive many of your decisions and steps that follow so it's important to be specific, especially at a high-level. For example, do you want to implement a solution to provide for:

    - Health care services between your health care professionals and their patients in different locations in real-time, using two-way video and audio communication?
    - Health care services between remote specialists in different locations and your patients in real-time, using two-way video and audio communication?
    - Health care consults between your health care professionals and others in different locations in real-time, using two-way video and audio communication?
    - Store-and-forward services to electronically share clinical information that's been collected on a patient including images (i.e. x-rays, MRIs), documents (i.e. lab results, patient history), and video, to another location for evaluation and consultation?
    - Remote patient monitoring of your patients' vital signs and other health data?

    This Toolkit can assist with the first three-solutions/use cases. It was designed specifically to accomplish the first solution in response to the COVID-19 public health emergency (PHE). The answer to this step will help narrow your vendor selection and will help your videoconferencing platform vendor design a solution that's customized to your needs on the front end of the process. Solutions designed to meet your specific needs before implementation are generally going to be more efficiently designed, implemented and affordable than those that need to be retrofitted on the back to accomplish something different than was originally defined.

2. **Define your organization's goals and metrics to evaluate performance.** Be clear on specific goals or objectives the solutions identified above will accomplish for your organization when successfully implemented. Once you outline these, it's easier to choose measures that support the achievement of your goals for launching telehealth. Evaluating possible measures against this bar will help reduce their numbers and prioritize those that are most meaningful to defining success. These may be meeting timelines and processes measures through implementation and then evolve to volumes, satisfaction levels, and billing and reimbursement success. Consider metrics you're already collecting through your EMR. Pick a few that can be reported right out the gate and regularly to signal accomplishment, build momentum, and isolate improvement areas.

Later, monitoring telehealth services and identifying what's working and what needs fine-tuning will yield continuous improvement opportunities that can drive all sorts of quality measures. Recognize improvements that have been implemented and celebrate improvements in measures that are achieved and contribute to telehealth's success.

3. **Identify a provider champion and an implementation lead.** Choose a provider champion with a strong interest who will be delivering services and sees the need and value to moving now. They should be integrally involved in the success of this new delivery model, and possess influence with providers and frontline staff. Back them up with a credible leader who understands clinic operations deeply, and knows how to get things done. Accomplishing this work and addressing these considerations will need to be their top priority.
4. **Define the implementation essentials and focus immediate efforts and resources on them**. There will be many tempting opportunities to expand the scope. Name and document them along with their key benefits while you're thinking of it. If it's not essential to what you need to accomplish now, then set it aside to focus on launching telehealth. This also demonstrates to your team that you understand, value, and protect their limited time, energy and resource. An example that comes to mind: The University of Kansas Hospital launched telehealth two years ago and is just now beginning work to integrate its videoconferencing platform (VCP) to its EMR. The two have worked side by side for some time, even during the hospital's transition of ambulatory services to telehealth during this PHE, which now represents well over 1,000 visits each day. Deferring non-essentials can also enhance your ultimate solution by providing value-adding experience and insight, including telehealth utilization and post-pandemic regulations, to enable better decision-making and design when the time is right.
5. **Choose your technology wisely.** While government agencies and other payers are providing much latitude in the video-conferencing platforms that can be used during the public health emergency to meet the standard of "telehealth", take a longer-term view when choosing your platform. Ask yourself which options will still be supported after the crisis ends. Areas where regulations have been relaxed and/or won't be audited are worthy of attention. For example: HIPAA rules. An HHS Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency stated:

   "OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency... A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients."

   Of note, Kansas Medicaid continues to require HIPAA-secure technologies. Prioritize vendors with HIPAA compliant solutions that will enter into HIPAA Business Associate Agreements (BAAs) in connection with their services. Health & Human Services provides a listing of vendors that have represented they offer such solutions on its Health Information

Privacy page. If you're considering a vendor you *don't* think will make the cut, be sure you discuss whether your organization will be comfortable going through the process of finding, funding, learning, and implementing a solution again in a post-PHE environment.

Note: Some say to select your technology vendor after completing your workflow, but in this instance, consider moving it ahead of workflow. This sequence will likely better support your organization's timeline and lead to less of a desire to customize your solution which takes time and money from your implementation. This is likely a good time to go with experienced vendors offering proven, standard solutions.

Selection considerations:

- **HIPAA compliant and encryption** (BAA is a must if these conditions are met)
- Products and services, and customization offered
- Data security standards
- Reliability standards (connectivity)
- Interoperability, i.e. can be integrated to EMR (at future point), scheduling system (if outside EMR)
- Technical and training support
- Customer service response standards
- Contract term, keeping in mind specific changes prompted with COVID-19 PHE are temporary
- Payment rates and structure
- History
- Financial stability/source(s)/growth
- Involvement in any legal action
- References
- Recognitions and awards

6. **Develop your telehealth workflow.** This is an essential component of launching telehealth that guides important decisions like roles and responsibilities, sequencing of activities, and configuration of technology. Your team will need to quickly determine what steps need to be taken in what sequence, how they are to be completed and by whom, to implement effectively. Consider establishing a telehealth workflow task force to develop yours that includes two individuals from each function that will have responsibilities prior to, during, and following patient encounters. It doesn't need to be a long-term engagement. Defining the workflow can be accomplished in one, possibly two half-day sessions because you have a template to start with (page 33). It might include staff members responsible for:

    - Scheduling patients
    - Registering patients
    - Communicating with patients and completing consents
    - Rooming patients
    - Providing telehealth services and completing associated documentation
    - Engaging with patients on post-encounter follow-ups
    - Coding telehealth encounters
    - Billing and collecting for telehealth encounters

- Plus, your Implementation Lead (if not represented above or below) and representatives from:
  - IT
  - Quality
  - Clinic Operations and Management

Two individuals from the teams who do this work will encourage discussion among subject matter experts so optimal solutions are identified across the entire workflow. It also improves training. With two trainers in each area, key changes can be reinforced, and each has the support of the other to explain and back them up. Before it's finalized, consider having task force members share the workflow with others in their area, so gaps and good ideas can be vetted with the rest of the task force, and incorporated as appropriate before the workflow is piloted. Gathering feedback from critical support areas or partners – legal, interpreter services, and marketing for example, is important at this point. Consider meeting daily for the first 30 days, for 30 minutes to identify and assign responsibility and timelines for recommended adjustments.

Consider giving staff members a tool – a Word template, a notepad – whatever they will use, and for the first 30 days ask them to jot notes about successes and challenges, including when they experience rough spots and gaps in the workflow – anything that needs adjustment. Identify task force members to receive and forward these. Their time commitment to sharing them will be honored when they see them addressed in your daily huddles.

Before the workflow is piloted, initiate an Implementation Team to transition the Task Force's work to during the pilot stage. With the Implementation Lead at the helm, representation from the Workflow Task Force and others represented in the workflow, the Implementation Team can be tasked with putting a plan around bringing the workflow to life on a defined timeline.

7. **Define, document and distribute reasons for patient visits that are "telehealth appropriate".** The goal is enabling those responsible for registering, scheduling, and rooming patients to act efficiently on patient's behalf while setting the stage for quality care, with appropriate provider guidance. The list of covered telehealth services provided by CMS for the COVID-19 PHE may be a good starting point for providers' use in creating this tool. Consider defining criteria, conditions, and appointment types (i.e. annual wellness, treatment follow-up, etc.) they believe will generally be good fits for telehealth, doing the same for those that generally will **not** be a good fit, and documenting a pathway for decision-making when the staff is unsure. In determining patient appropriateness, risk management considerations including risks of in-session medical crisis, behavioral crisis, safety in the home setting, and other clinic/cultural factors that may impact the telehealth encounter need attention. This proactive step gets people on the same page and will reduce calls and stop-bys, and denials as well. Distribute the list to all clinical, registration, scheduling, and rooming staff. Don't talk yourself out of doing this because you're not sure your list is complete; this is a good place to apply the 80% rule. The tool can be refined as you go. For this reason, it is important to keep track of who needs/receives the list so the most updated version can consistently be provided to them.

8. **Use personal means and every opportunity to promote acceptance.** Frequent and personal communications will facilitate faster adoption of telehealth by staff and patients alike, and this is a key consideration for successful implementation. There will be a long-tailed return on every investment you make to ensure that every staff member and every patient has a first, and a **positive** first experience using telehealth. The goal is building confidence and positive word of mouth that's achieved through prior success. With staff, you'll accomplish this with training and a well-documented and vetted workflow. With patients, you'll accomplish this with a well-executed workflow. For both audiences, frequent and personal communications are essential. Personal communications provide a two-way opportunity, and use the technology (not just having it "on-hand"). The goal is accomplishing successful rehearsals – multiple for staff members who are interfacing with patients – before "prime time".

   - For clinicians and staff members who will interface with patients, consider setting a standard of 5 successful implementations of their steps in the workflow, with a team member playing the role of staff member and/or patient, over a minimum of two days, prior to performing their roles with their first patient.
   - For patients, we learned when implementing the transition in their location from clinic to home for telebehavioral health services, that planning time for a staff member to help them accomplish the steps necessary to access the videoconferencing platform (VCP), and to successfully test it prior to their first appointment was key to a positive first experience with in-home telehealth. This can be done using existing contacts as shown below.

Here's an approach to patient communications that blends what The University of Kansas Hospital team implemented in Kansas City and the Kansas Rural Telebehavioral Health Network team implemented with its first 10 rural clinic partners. The emphasis on personal, two-way communications is intentional.

Telehealth Implementation Patient Communications Matrix

Modality	**Objective**
Timing: Prior to Telehealth Services Implementation	
Mail letters with inserts to patients	• Communicating transition to visits from home via telehealth with resources: – Telehealth How To (tip sheet insert about connection and session expectations) – Coping with Stress Through the COVID-19 Public Health Emergency
Email to patients	• Communicating transition with link to resources
Timing: During Telehealth Services Implementation	
Office visit WHENVER POSSIBLE depending on clinic's access realities during COVID-19	• Assisting patients to download the VCP software, and demonstrating what they will do for their telehealth visit so they successfully accomplish this prior to their first appointment
Telephone call to schedule appointment	• Confirming receipt of letter and sharing concern for patient • Reviewing highlights, listening to concerns, and answering questions • Scheduling telehealth appointment
Telephone call to confirm appointment	• Completing the steps necessary to access the VCP with the patient, and successfully testing It prior to patient's first appointment
Email to patients	• Promoting telehealth appointments and "how tos"
Videoconference	• Providing patient care via telehealth
Telephone	• Following up on provider's instructions and gaining feedback on the patient's experience with telehealth

Templates for patient letters, scripts for telephone contacts, and examples of emails are provided in the Toolkit.

9. **Prioritize training.** Staff members from every area represented on the task force will need training so they can reliably perform their roles. Training, or the lack of it, directly impacts what your staff and patients will experience. Because it will be new to each of them to be "seen from home", it's imperative that clinic staff is acting with confidence and consistency to set the tone for telehealth success. This will likely be the single greatest determinant of each patient's satisfaction with telehealth, and interest in using it again for future visits.

   Consider:

   - Involving the VCP provider in hands on training using the platform by function/swim lane on the workflow
   - Training on the workflow and practice sessions with staff members modeling the workflow from start to finish

- Offering “tele-providing” training to those who are new to providing services via telehealth
- Supporting communication updates and monthly touch points with staff to share successes and challenges to reinforce training messages
- Access Care Collaborative and Heartland Telehealth Resource Center supports for questions and ongoing telementoring needs. The Heartland Telehealth Resource Center is a federally funded program serving Kansas, Missouri, and Oklahoma. It offers telehealth technical assistance to support telehealth start-up and best practices to help build sustainable services. For more information, contact Dr. Eve-Lynn Nelson through www.Heartlandtrc.org or (877) 643-HTRC.

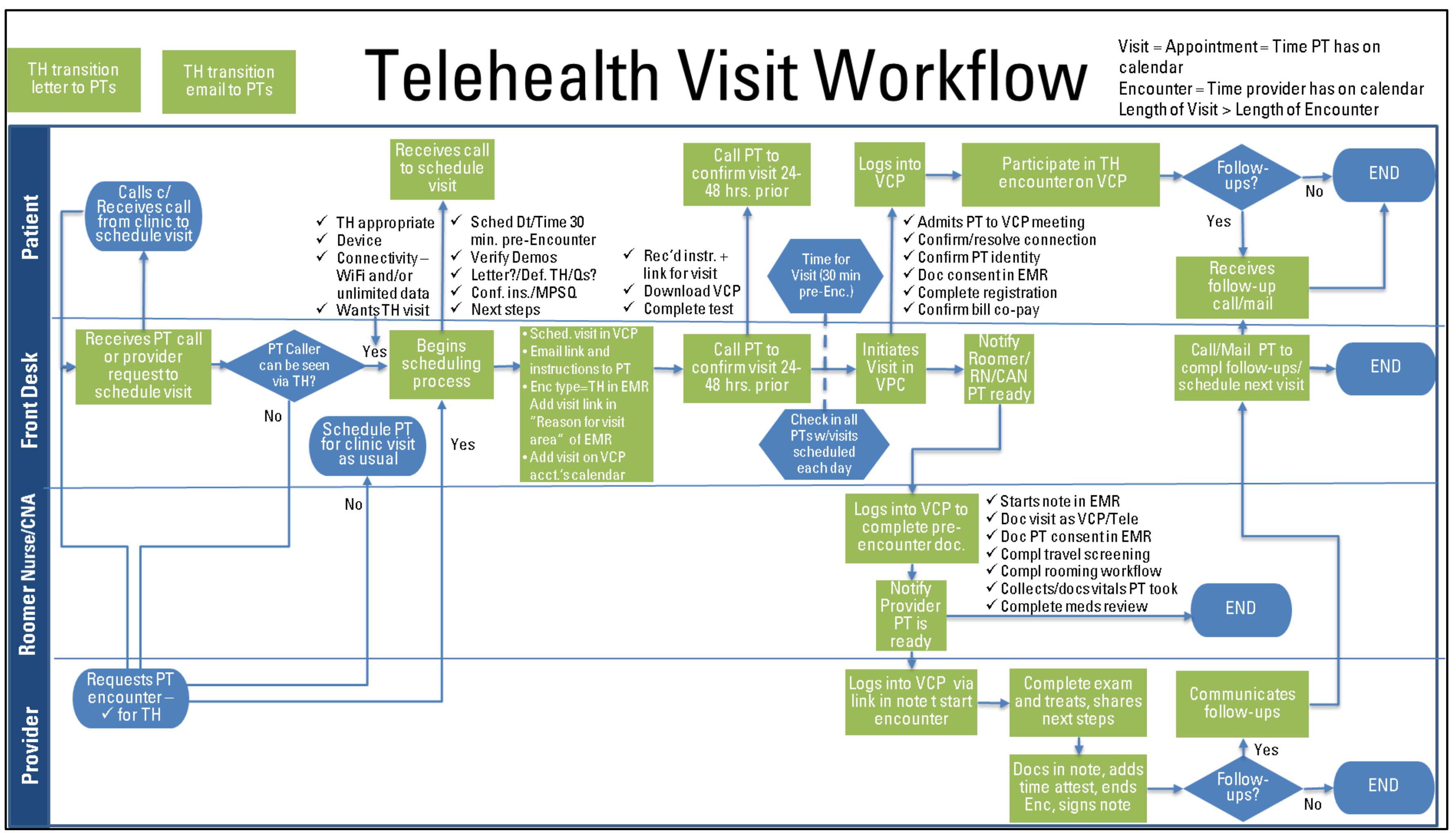
10. **Integrate your telehealth delivery model into your organization’s strategic plan.** Consider how you can use this opportunity to strengthen your current telehealth strategy or to launch a telehealth strategy as part of your strategic business plan. Document this while it’s fresh and update it with learnings prior to your strategic planning effort. If your organization isn’t yet established with specialists who can meet important clinical needs within your community, consider and document all the ways that implementing telehealth to provide services to your patients as a distant site, positions you better to engage with specialists who would offer clinical value to your community.

Additional Resources:

- A listing of vendors Health & Human Services provides on its Health Information Privacy Page have represented they offer HIPAA compliant solutions and will enter into HIPAA Business Associate Agreements (BAAs) with clients.
- A list of covered telehealth services provided by CMS for the COVID-19 PHE most recently updated on 3/31/20 CMS Approved TH Codes 3.31.20 presented on March 18 by Kathy HSU Wibberly, PhD, Director, Mid-Atlantic Telehealth Resource Center, is a very good, 50-minute high-level overview for those just getting started.

THE UNIVERSITY OF KANSAS HEALTH SYSTEM
Care Collaborative

Telehealth Workflow Template



10-Step Telehealth Implementation Checklist

A high-level checklist to aid your organization's efforts to implement telehealth in an ambulatory setting, promoting a thoughtful approach that recognizes important fundamentals of your implementation plan.

☐ 1. Define what your organization needs to accomplish with telehealth **now.**
- Use community and business assessments.
- Policy at federal and state levels, specifically based on type of organization (i.e. RHC, FQHC, et al):
  - What can your organization do? What can it not do?
  - What regulations, statutes, and guidelines apply?
  - What are the rules around reimbursement?

☐ 2. Establish specific organizational goals and metrics.
- *What's your why?* What specific strategic objectives/outcomes must you accomplish by doing the thing(s) above?
- What metrics indicate your organization has successfully accomplished the objective/outcome?

☐ 3. Identify a provider champion and implementation lead.
- Which provider is passionate, has influence with your organization's med staff, and sees the "now" opportunity?
- Which leader broadly understands the operations/"how things work" of your organization and gets things done?

☐ 4. Define the implementation **essentials.**
- What do answers to the above presume or require of your organization?
  - For each, rate on a 1-5 scale from "Can come back to later" to "Success depends on it".
- For others that will emerge, ask what adding it mean to your current scope's:
  - Team/human resource, i.e.do it have the bandwidth?
  - Speed of implementation and target launch date?
  - Cost
  - Design

  And, what is the Impact to current your organization's business functioning?

☐ 5. Choose your technology wisely.
- What platforms are similar organizations, that are trying to accomplish what you are, using and how is it working for them?
- What criteria does the solution needs to meet, i.e. is it HIPAA compliant?
  - Refine it as demos/proposals are reviewed/compared.
- Follow-up on references – you'll be surprised what you can learn.

☐ 6. Develop your telehealth workflow.
- Define a Workflow Task Force and an Implementation Team.
- What activities, in what order, completed by what role/function?
- Start with the Telehealth Workflow template provided.

☐ 7. Determine the clinical reasons for patient visits that are "telehealth appropriate".
- Gain med staff, coding and legal approval to defined list
- Document list to create a reference tool
- Identify recipients and distribute (ensure updates go to all recipients)

☐ 8. Use personal means and every opportunity to gain acceptance/use.
- Patient communication plan: What medium, what sequence, by and to whom?
- Script: Simply stated, what is telehealth?
- Protocol: Simply stated step-by-step for a telehealth visit using technology

☐ 9. Prioritize training.
- Staff training plan **by function** (including VCP provider)
- Patient training plan for all patient-facing roles
- Patient training for using telehealth
- Tracking tool for VCP users to help identify/prioritize fixes

☐ 10. Integrate your telehealth solution to your organization's strategic plan (when you get it out the gate).
- What opportunities does the telehealth services delivery model you implemented set you up for, that are aligned with your current goals?
- What new goals answer other or new community and business needs?

Additional Resources:

- Telehealth Essentials Checklist Training recorded webinar presented on March 18 by Kathy HSU Wibberly, PhD, Director, Mid-Atlantic Telehealth Resource Center, is a very good, 50-minute high-level overview for those just getting started.
- GPTRAC Detailed Telehealth Checklist for a more detailed checklist. This checklist frames the telehealth opportunity from the perspective of a rural site implementing telehealth as an originating site (where the patient is located). This was the option for RHCs and FQHCs prior to the COVID-19 PHE, although the activities identified are generally the same for launching telehealth as the distant site (where the provider is located).
- The Mid-Atlantic Telehealth Resource Center offers a thorough and easy to navigate Vendor Selection Toolkit you might find helpful to mapping your course.

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Section 3: Tools and Templates to Aid Implementation of Telehealth

Overview

This final section provides specific tools and templates your organization can customize to implement its telehealth services more effectively and efficiently. They were developed for the Kansas Rural Telebehavioral Health Network and The University of Kansas Hospital to aid their telehealth implementations in ambulatory settings. Some serve as examples of communications you'll create to build awareness and engage patients in telehealth. Some can be easily customized by simply adding your organization's name, and others require more modification to accurately describe the sequence and scope of activities reflected in your unique workflow. All are intended to prompt thorough planning and discussion to help patients and "patient-facing" clinic staff seamlessly and successfully make the transition from office- to home-based services.

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Direct to Patient Communications

Telehealth Implementation Patient Communications Matrix

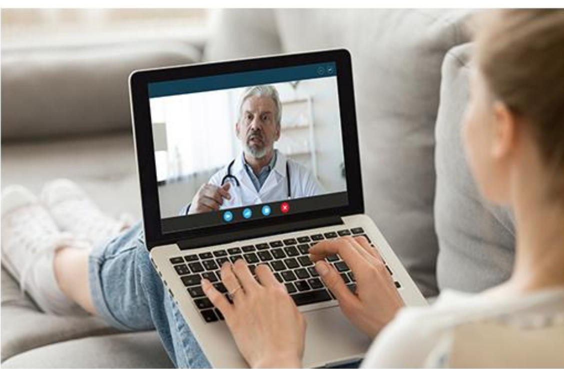
Timing	Modality	Objective
Prior to Telehealth Services Implementation	Mail letters with inserts to patients	• Communicating transition to visits from home via telehealth with resources: – Telehealth How To (tip sheet insert about connection and session expectations – Coping with Stress Through the COVID-19 Public Health Emergency
	Email to patients	• Communicating transition with link to resources
During Telehealth Services Implementation	Office visit WHENVER POSSIBLE depending on clinic's access realities during COVID-19	• Assisting patients to download the VCP software, and demonstrating what they will do for their telehealth visit so they successfully accomplish this prior to their first appointment
	Telephone call to schedule appointment	• Confirming receipt of letter and sharing concern for patient • Reviewing highlights, listening to concerns, and answering questions • Scheduling telehealth appointment
	Telephone call to confirm appointment	• Completing the steps necessary to access the VCP with the patient, and successfully testing It prior to patient's first appointment
	Email to patients	• Promoting telehealth appointments and "how tos"
	Videoconference	• Providing patient care via telehealth
	Telephone	• Following up on provider's instructions and gaining feedback on the patient's experience with telehealth

UKHS Telehealth Appointments Now Available Email

Click here to view this message in a browser window.

MyChart

Telehealth appointments now available



The care team at The University of Kansas Health System is always committed to providing efficient, convenient, high-quality care.

For the ongoing health and safety of our patients and their loved ones, we've expanded our telehealth services. For many types of primary and specialty care, patients can connect with providers electronically from the comfort of home.

Advantages to telehealth appointments include:

- Efficiently, seamlessly manage routine or chronic care needs
- Safely obtain needed care while practicing physical distancing
- Save the time and cost of transportation
- Avoid exposure if you or people around you may be sick
- Receive insurance coverage as with in-person visits

If a scheduled appointment was recently canceled or postponed, or you've been hesitant to plan needed care, we encourage you to contact your provider's office or call 913-588-1227 to discuss your needs. A telehealth visit may be a fit for you.

Learn more about telehealth. Our website provides information on how to prepare your device for a visit and describes the visit process.

Care for routine or chronic needs is important. We hope telehealth visits will provide comfort and flexibility for conveniently obtaining timely care. We appreciate the opportunity to serve you.

Sign in to MyChart

Visit MyChart on your smartphone or desktop. If you forget your sign-in information, select **Forgot Username** or **Forgot Password**. Or call us at 913-588-4040.

Copyright © 2020 The University of Kansas Health System
Our address is 4000 Cambridge Street, Kansas City, KS 66160, USA

If you do not wish to receive future email, click here.
(You can also send your request to **Customer Care** at the street address above.)

Existing Medicare PT Telehealth Location Change Letter

Insert Logo Here

<Date>

Dear <Name>,

In response to the public health emergency caused by the COVID-19 virus, Medicare has expanded coverage of telehealth. As a result, you may continue receiving health care services from your current provider at <site name> right from your home. These in-home telehealth services will be available for the duration of the public health emergency. Many aspects of your appointment will be familiar. The primary change is you will be connecting with your provider at home using your own computer, tablet, or cell phone. Our staff will provide technical support in advance of your appointment to help get you set-up to receive these services.

There are several benefits to telehealth from your home. Most importantly, your exposure to the COVID-19 virus is reduced because for the time being, you will not need to visit the clinic to receive care.

The same staff members you're used to seeing at our office will help make this change easy for you. Getting familiar with the enclosed handouts will also be a big help.

- First, when you schedule your appointment, we'll review this change and the enclosed information with you, help with how to connect, and answer your questions.
- Then, when we call to confirm your appointment, we'll help you download what you need on your cell phone, tablet, or computer, to have the same face-to-face experience with your provider that you currently do.
- The day of your appointment, we'll make sure you and your provider connect by video and are able to see and talk to one another for your visit – just like you do at the office.

Many things will stay the same as your appointments move from our clinic to your home. Your provider, and the quality of your visits will be the same. And there are no additional fees for these appointments.

Thank you for being flexible and taking care of yourself by staying at home and using our telehealth services during this challenging time. Office visits will resume when COVID-19 is controlled and Medicare gives the "okay".

Sincerely,

<Patient's Provider>

Enclosures: Telehealth Visits
Patient Guide to Managing Stress During the COVID-19 Virus Outbreak

Existing Non-Medicare PT Telehealth Location Change Letter

Insert Logo Here

<Date>

Dear <Name>,

In response to the public health emergency caused by the COVID-19 virus, insurance coverage for the use of telehealth has been expanded. As a result, you may continue receiving health care services from your current provider at <site name> right from your home. In-home telehealth services will be available for the duration of the public health emergency. Many aspects of your appointment will be familiar. The primary change is you will be connecting with your provider at home using your own computer, tablet, or cell phone. Our staff will provide technical support in advance of your appointment to help get you set-up to receive these services.

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The same staff members you're used to seeing at our office will help make this change easy for you. Getting familiar with the enclosed handouts will also be a big help.

- First, when you schedule your appointment, we'll review this change and the enclosed information with you, help with how to connect, and answer your questions.
- Then, when we call to confirm your appointment, we'll help you download what you need on your smartphone, tablet or computer, to have the same face-to-face experience with your specialist that you currently do.
- The day of your appointment, we'll make sure you and your provider connect by video and are able to see and talk to one another for your visit – just like you do at the office.

Many things will stay the same as your appointments move from our clinic to your home. Your provider, and the quality of your visits will be the same. And there are no additional fees for these appointments.

Thank you for being flexible and taking care of yourself by staying at home during this challenging time. Office visits will resume when COVID-19 is controlled and this public health emergency passes.

Sincerely,

<Patient's Provider>

Enclosures: Telehealth Visits
Patient Guide to Managing Stress During the COVID-19 Virus Outbreak

New Medicare PT Telehealth Location Change Letter

Insert Logo Here

<Date>

Dear <Name>,

In response to the public health emergency caused by the COVID-19 virus, Medicare has expanded coverage of telehealth. As a result, you can receive health care services with a provider at <site name> right from your home. These in-home telehealth services will be available for the duration of the public health emergency. You will be connecting with your health care provider at home using your own computer, tablet, or cell phone. Our staff will provide guidance and technical support in advance of your appointment to help get you set-up to receive these services.

There are several benefits to telehealth from your home. Most importantly, your exposure to the COVID-19 virus is reduced because for the time being, you will not need visit the clinic to receive care.

Our staff members have a great deal of experience assisting our patients prior to their appointments, and they will help make it easy for you to receive services over your computer, tablet, or cell phone. Getting familiar with the enclosed handouts will also be a big help.

- First, when you schedule your appointment, we'll review this change and the enclosed information with you, help with how to connect, and answer your questions.
- Then, when we call to confirm your appointment, we'll help you download what you need on your computer, tablet, or cell phone to help ensure you have a successful visit with your provider using telehealth.
- The day of your appointment, we'll make sure you and your provider connect by video and are able to see and talk to one another for your visit.

Our team looks forward to working with you. Feedback from current patients to this change has been very positive, and we are eager for you to experience the same.

Thank you being flexible and taking care of yourself by staying at home and using our telehealth services during this challenging time. Office visits for these services will resume when COVID-19 is controlled and Medicare gives the "okay".

Sincerely,

<Provider Name>

Enclosures: Telehealth Visits
Patient Guide to Managing Stress During the COVID-19 Virus Outbreak

New Non-Medicare PT Telehealth Location Change Letter

Insert Logo Here

<Date>

Dear <Name>,

In response to the public health emergency caused by the COVID-19 virus, insurance coverage for the use of telehealth has been expanded. As a result, you can receive health care services with a provider at <site name> right from your home. These in-home telehealth services will be available for the duration of the public health emergency. You will be connecting with your health care provider at home using your own computer, tablet, or cell phone. Our staff will provide guidance and technical support to help get you set-up to receive these services.

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Our team looks forward to working with you. Feedback from current patients to this change has been very positive, and we are eager for you to experience the same.

Thank you for being flexible and taking care of yourself by staying home and using our telehealth services during this challenging time. Office visits for these services will resume when COVID-19 is controlled and this public health emergency passes.

Sincerely,

<Patient's Provider>

Enclosures: Telehealth Visits
Patient Guide to Managing Stress During the COVID-19 Virus Outbreak

Telehealth Visit How To

Preparing for a Telehealth Visit with Your Health Care Provider

Frequently asked questions

We believe you will find your telehealth visit convenient and effective. Please review these commonly asked questions and prepare your device for your visit.

What do I need to conduct a Zoom visit?

- Internet access.
- A device – laptop, phone, tablet or computer – with audioconferencing and videoconferencing functions (i.e., a camera and speaker).
- Installed Zoom app or access to zoom.us via computer.

How do I Install Zoom?

Zoom for Android phone/tablet

- Open the Google Play Store on your device.
- Search for Zoom Cloud Meetings.
- Locate and tap the entry by zoom.us.
- Tap Install.
- Read the permission listing.
- If the permissions listing is acceptable, tap Accept.
- Allow the installation to complete.

Zoom for iOS phone/tablet

- Tap the App Store icon on your device.
- Tap Search the bottom right of your screen.
- Enter Zoom in the search text box.
- Select Zoom Cloud Meetings from the available app choices.
- Tap Get.
- Tap Open.

Zoom for Windows and Mac computer

- Visit Zoom Download Center: **zoom.us/download.**
- Click Download below Zoom Client for Meetings.
- Click and Open the downloaded file. It is typically saved to your Downloads folder.
- Follow the prompts to install the application on your computer.

How do I join a Zoom Meeting?

- Open the Zoom app on your device.
  - Enter Meeting ID provided by Coordinators.
  - Tap Join Meeting.

EXAMPLE

- Customize based on your videoconferencing platform
- Include specific steps
- Clearly address variations based on operating platforms and devices
- Minimize the number of steps where possible

QUESTIONS? We can help.
Call (xxx) xxx-xxxx
Ask for Scheduling

Continued on the Back Page

Patient Guide to Managing Stress During COVID-19

MARCH 2020

Patient Guide to Managing Stress During the COVID-19 Virus Outbreak

Information about COVID-19 continues to change as new details about the virus emerge. If there is an outbreak in your community, you may be concerned with how to best take care of yourself and family members. Knowing up-to-date information about the outbreak and how to be prepared can reduce stress and decrease worry. This handout will help you think about how the COVID-19 outbreak might impact you and your family members both physically and emotionally and what you can do to help you and loved ones cope.

Tips for managing social distancing and isolation

Understand that it is okay to feel overwhelmed, anxious, and worried about what may happen. With flexibility and creativity—there are actions that we can take to help feel more prepared and reduce our stress during times of uncertainty, while minimizing our risk of being exposed to COVID-19.

Stay connected

- Develop a plan for maintaining contact. While individuals are asked to physically distance themselves from others, make a plan to connect via video chat, text, or phone. Scheduling times to connect with your friends and family can also be helpful and can be another way to reduce stress. Being open to sharing how you feel about this situation with others can help reduce stress.
- If you feel overwhelmed or distressed, reach out for counseling and support within your community - to local counselors, to specialsts from The University of Kansas Hospital using telebehavioral health services provided by your primary care clinic, to community mental health clinics and religious leaders.
- Identify how you will stay up-to-date with evolving information about COVID-19. The CDC is a regularly updated resource.
  CDC: https://www.cdc.gov/coronavirus/2019-ncov/index.html
  CDC Information on children and COVID 2019: https://www.cdc.gov/coronavirus/2019-ncov/specific-groups/children-faq.html https://healthychildren.org/English/health-issues/conditions/chest-lungs/Pages/2019-Novel-Coronavirus.aspx

Focus on what you can control

- Feeling prepared is a good way to lessen the stress and worry associated with COVID-19. You can create a kit of supplies to last you and any family members 3-5 days including any medications that you take regularly, water/food/electrolytes, thermometer, medicines for fever, and hygiene supplies.
- Create a list of resources in your community. This may include important phone numbers, websites, social media accounts of schools, doctors, public health authorities, social services, community mental health center, and crisis hotlines.
- During this time, grocery stores, pharmacies, gas stations, some take-out/delivery only restaurants, and hospitals remain open. Some grocery stores are offering curbside grocery pick up or specialized shopping hours for individuals who may be at higher risk from getting sick. Whenever possible—opt for curbside pick up of home delivery to minimize contact with others. If you are at higher risk of getting sick from COVID, identify if friends or family are able to pick up groceries and or medications for you.
- Focus on the "here and the now." During stressful times it can be tempting to worry about the future. Instead problem-solve and set achievable goals for each day.

Foster resiliency

- Recognize, acknowledge, and accept the reality of this new situation.
- Make a plan for how you will approach feelings of being overwhelmed or distressed. Preparing can make you feel more in control of how you will approach these feelings if they arise.
- Shift your negative statements into statements that allow you to function with less distress. Try changing "this is a terrible time" to "this is a terrible time, AND I can get through this."

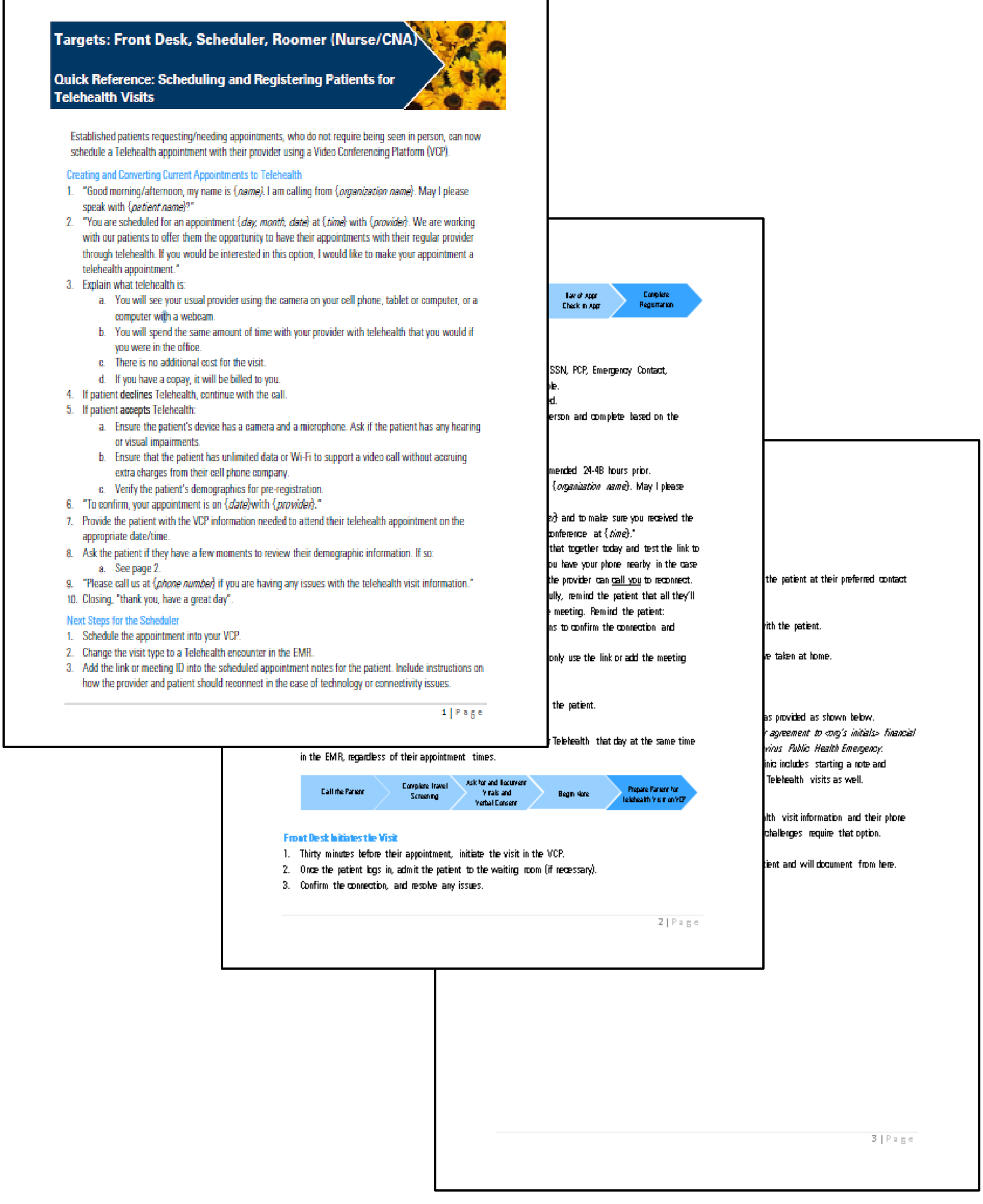
Adapted from: NCTSN https://www.nctsn.org/sites/default/files/resources/fact-sheet/outbreak_factsheet_1.pdf, Veteran's Affairs resources https://www.ptsd.va.gov/covid/index.asp

Clinic Training/Tip Sheet Templates

Practical Tips and Reminders for Telehealth Visits

Pre-Implementation	
1	Be thoughtful about the number of VCP licenses/accounts are needed to balance cost and capacity. For example, basing it on the "least common denominator", provides the number of licenses needed if all providers were performing telehealth visits simultaneously. That number can be reduced to account for the likelihood this occurs and the proportion of visits you expect to deliver via telehealth; consider a 20% reduction for these factors.
2	Consider setting up accounts with non-user specific email addresses, i.e. TeleH1!@kumc.edu, TeleH2!@kumc.edu, etc. If a VCP allows only one account per email address, and a provider has an existing account for faculty work, another may not be set up for that individual's clinical use.
3	Create a calendar for each VCP account that is used. Ensure front desk staff who schedule telehealth visits, also schedule a meeting on the account-specific calendar, and staff members who will participate in the call, and include VCP link/Meeting ID/Password info in the invite. The schedulers that who set up the visits are also responsible for keeping it up-to-date. This will ensure visibility to which accounts are in use when, so double-booking that could lead to interruptions is avoided.
4	If passwords are required to access your meetings, keep them SIMPLE so they are easy for patients to remember and to write down accurately.
5	Be prepared to offer resources to meet patient needs that can be anticipated, for example, if a patient using a desktop computer doesn't have a camera, have a couple webcam options handy to share. Another example is checking with local pharmacies to see if they are delivering right now and if charges apply, so if a patient needs meds or a thermometer to report their temp, you can help problem-solve.
6	Train patients, providers and clinic staff who will use the VCP how to use its chat feature to communicate should issues arise, i.e. poor connection, "freezing", audio issues, etc.
Pre-Encounter	
7	Verify patient meets technology/connectivity requirements to complete a telehealth visit (add requirements to patient scheduling/registration check-list).
8	Assign accountability to the scheduling staff for creating visits/meetings in the VCP immediately after each visit via telehealth is confirmed with the patient. This is a critical step.
9	Schedule patient visits 30 minutes prior to provider's start time to ensure ability to join videoconference and complete all pre-encounter entries in the EMR.
10	Add the VCP link for patient encounters into the "Reason for visit" field in the EMR for the provider's use
11	Make sure the patient has a dial in number to use when a back-up is needed to complete their visit.
12	Inform patients that telehealth visits may run shorter than in-clinic visits due based on insurance coverage.
Encounter	
13	Consistently remind providers, schedulers and roomers to capture patients' verbal consent and to enter it in a visible place within the note, so multiple people are checking for it. The confirmation of verbal consent is required for reimbursement.
14	Here are vital signs that might be reportable by patients from home: • Temperature (note type of thermometer used) • Blood pressure (note type of BP cuff used and proper protocol followed) • O2 level oximetry (pulse oximeter) • Pulse (manual wrist counting for 30seconds, smart watch, phone app, pulse oximeter) • Height and weight • Other Smartwatch and activity data

Quick Reference: Scheduling and Registering Patients for Telehealth Visits



Targets: Front Desk, Scheduler, Roomer (Nurse/CNA)

Quick Reference: Scheduling and Registering Patients for Telehealth Visits

Established patients requesting/needing appointments, who do not require being seen in person, can now schedule a Telehealth appointment with their provider using a Video Conferencing Platform (VCP).

Creating and Converting Current Appointments to Telehealth

1. "Good morning/afternoon, my name is (*name*). I am calling from (*organization name*). May I please speak with (*patient name*)?"
2. "You are scheduled for an appointment (*day, month, date*) at (*time*) with (*provider*). We are working with our patients to offer them the opportunity to have their appointments with their regular provider through telehealth. If you would be interested in this option, I would like to make your appointment a telehealth appointment."
3. Explain what telehealth is:
   a. You will see your usual provider using the camera on your cell phone, tablet or computer, or a computer with a webcam.
   b. You will spend the same amount of time with your provider with telehealth that you would if you were in the office.
   c. There is no additional cost for the visit.
   d. If you have a copay, it will be billed to you.
4. If patient **declines** Telehealth, continue with the call.
5. If patient **accepts** Telehealth:
   a. Ensure the patient's device has a camera and a microphone. Ask if the patient has any hearing or visual impairments.
   b. Ensure that the patient has unlimited data or Wi-Fi to support a video call without accruing extra charges from their cell phone company.
   c. Verify the patient's demographics for pre-registration.
6. "To confirm, your appointment is on (*date*) with (*provider*)."
7. Provide the patient with the VCP information needed to attend their telehealth appointment on the appropriate date/time.
8. Ask the patient if they have a few moments to review their demographic information. If so:
   a. See page 2.
9. "Please call us at (*phone number*) if you are having any issues with the telehealth visit information."
10. Closing, "thank you, have a great day".

Next Steps for the Scheduler

1. Schedule the appointment into your VCP.
2. Change the visit type to a Telehealth encounter in the EMR.
3. Add the link or meeting ID into the scheduled appointment notes for the patient. Include instructions on how the provider and patient should reconnect in the case of technology or connectivity issues.

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in the EMR, regardless of their appointment times.

Call the Patient → Complete Travel Screening → Ask for and Document Vitals and Verbal Consent → Begin Note → Prepare Patient for Telehealth Visit on VCP

Front Desk Initiates the Visit

1. Thirty minutes before their appointment, initiate the visit in the VCP.
2. Once the patient logs in, admit the patient to the waiting room (if necessary).
3. Confirm the connection, and resolve any issues.

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Quick Reference Telehealth Unscheduled Telephone Encounters

Target: Ambulatory Providers

Quick Reference: Telehealth Unscheduled Telephone Encounters

This document published as a draft due to urgent need for COVID-19 and Telehealth Information

Telehealth visits may be scheduled or performed as an unscheduled telephone call using a Telephone Encounter. *Note: The CPT code listed below is applicable to MD and APP documentation and billing only.*

You may wish to contact patients directly while displaying the hospital or clinics main number instead of a personal cell phone number by downloading a free third-party application.

Call Patient for Unscheduled Visits → Create Telephone Encounter → Complete Documentation and Enter Charges → Close Encounter

Document Unscheduled Telehealth Calls

Unscheduled telephone calls with patients can be documented and charged for as a visit. There is no front desk check-in process for this visit.

Create an Encounter

1. Within your EMR, open the patient's chart.
2. Create a telephone encounter or the standard telephone call documentation for your facility.

Complete Documentation

1. Within your EMR, enter the reason for the call.
2. Create a new note.
   a. At the top of your note, the verbal consent must be documented every time: "Obtained patient's verbal consent to provide this clinical telephone call due to the Coronavirus Public Health Emergency".
   b. Indicate you spent 5-10 minutes on the call.
3. Document the rest of the telephone encounter as usual.

Enter Charges

1. Select CPT G2012 *(this is a 5-10 min virtual check in via telephone or other telecommunication device to decide whether an office visit or other service is needed).*

   \- OR -

   Select CPT 99359 or 99358 for before/after care. If you realize either of these CPTs, add a time-based billing attestation to your note to indicate the amount of time spent on the phone with the patient.

Close Encounter

1. Finish the note and close the encounter in your EMR.

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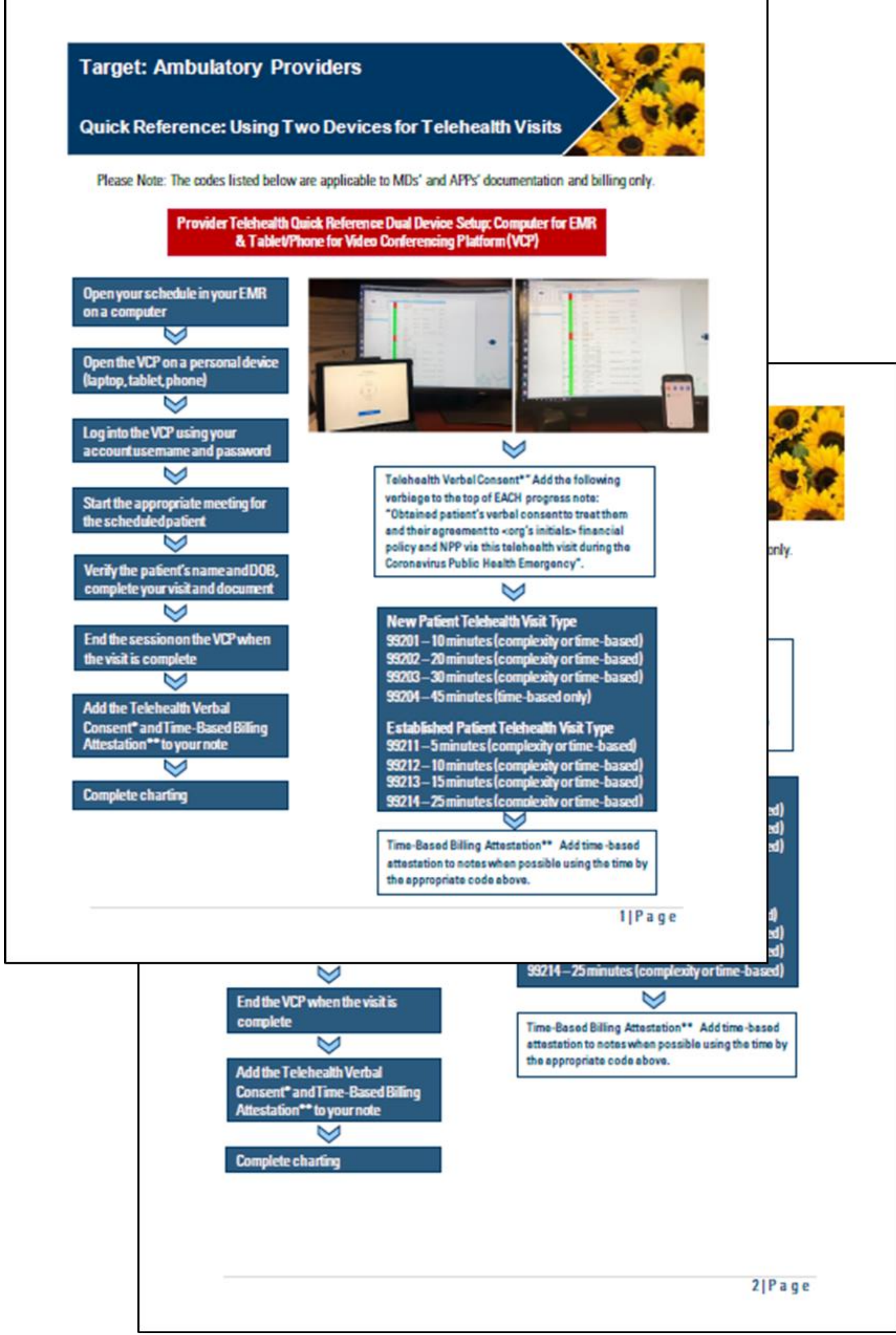
Quick Reference Guide Telehealth Encounters with One or Two Devices



Target: Ambulatory Providers

Quick Reference: Using Two Devices for Telehealth Visits

Please Note: The codes listed below are applicable to MDs' and APPs' documentation and billing only.

Provider Telehealth Quick Reference Dual Device Setup: Computer for EMR & Tablet/Phone for Video Conferencing Platform (VCP)

- Open your schedule in your EMR on a computer
- Open the VCP on a personal device (laptop, tablet, phone)
- Log into the VCP using your account username and password
- Start the appropriate meeting for the scheduled patient
- Verify the patient's name and DOB, complete your visit and document
- End the session on the VCP when the visit is complete
- Add the Telehealth Verbal Consent* and Time-Based Billing Attestation** to your note
- Complete charting

Telehealth Verbal Consent** Add the following verbiage to the top of EACH progress note: "Obtained patient's verbal consent to treat them and their agreement to <org's initials> financial policy and NPP via this telehealth visit during the Coronavirus Public Health Emergency".

New Patient Telehealth Visit Type
99201 – 10 minutes (complexity or time-based)
99202 – 20 minutes (complexity or time-based)
99203 – 30 minutes (complexity or time-based)
99204 – 45 minutes (time-based only)

Established Patient Telehealth Visit Type
99211 – 5 minutes (complexity or time-based)
99212 – 10 minutes (complexity or time-based)
99213 – 15 minutes (complexity or time-based)
99214 – 25 minutes (complexity or time-based)

Time-Based Billing Attestation** Add time-based attestation to notes when possible using the time by the appropriate code above.

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- End the VCP when the visit is complete
- Add the Telehealth Verbal Consent* and Time-Based Billing Attestation** to your note
- Complete charting

99214 – 25 minutes (complexity or time-based)

Time-Based Billing Attestation** Add time-based attestation to notes when possible using the time by the appropriate code above.

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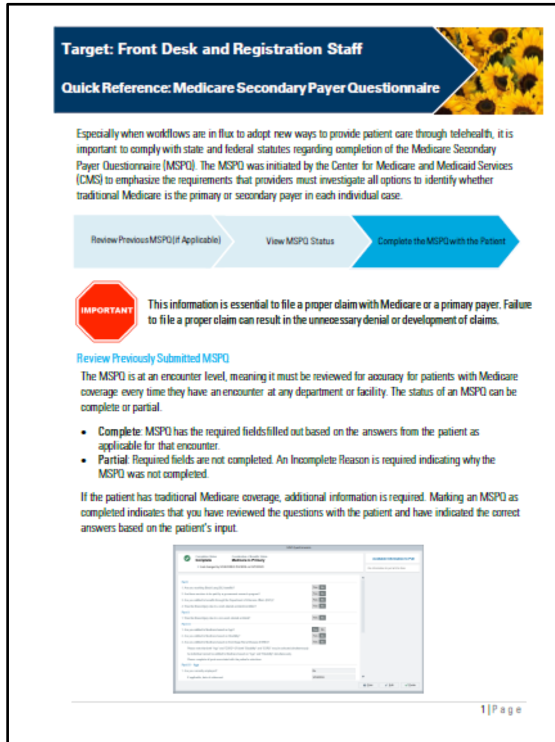
Medicare Secondary Payer Questionnaire



Target: Front Desk and Registration Staff

Quick Reference: Medicare Secondary Payer Questionnaire

Especially when workflows are in flux to adopt new ways to provide patient care through telehealth, it is important to comply with state and federal statutes regarding completion of the Medicare Secondary Payer Questionnaire (MSPQ). The MSPQ was initiated by the Center for Medicare and Medicaid Services (CMS) to emphasize the requirements that providers must investigate all options to identify whether traditional Medicare is the primary or secondary payer in each individual case.

Review Previous MSPQ (if Applicable) → View MSPQ Status → Complete the MSPQ with the Patient

IMPORTANT: This information is essential to file a proper claim with Medicare or a primary payer. Failure to file a proper claim can result in the unnecessary denial or development of claims.

Review Previously Submitted MSPQ

The MSPQ is at an encounter level, meaning it must be reviewed for accuracy for patients with Medicare coverage every time they have an encounter at any department or facility. The status of an MSPQ can be complete or partial.

- Complete: MSPQ has the required fields filled out based on the answers from the patient as applicable for that encounter.
- Partial: Required fields are not completed. An Incomplete Reason is required indicating why the MSPQ was not completed.

If the patient has traditional Medicare coverage, additional information is required. Marking an MSPQ as completed indicates that you have reviewed the questions with the patient and have indicated the correct answers based on the patient's input.

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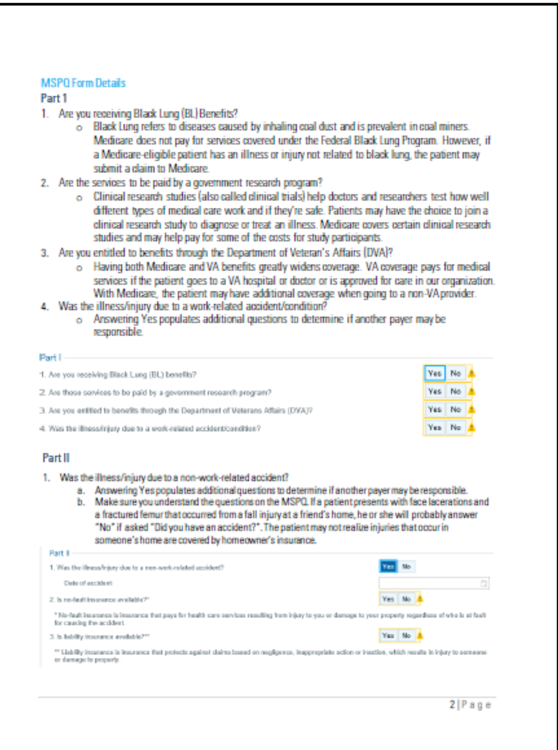

MSPQ Form Details

Part 1

1. Are you receiving Black Lung (BL) Benefits?
   - Black Lung refers to diseases caused by inhaling coal dust and is prevalent in coal miners. Medicare does not pay for services covered under the Federal Black Lung Program. However, if a Medicare-eligible patient has an illness or injury not related to black lung, the patient may submit a claim to Medicare.
2. Are the services to be paid by a government research program?
   - Clinical research studies (also called clinical trials) help doctors and researchers test how well different types of medical care work and if they're safe. Patients may have the choice to join a clinical research study to diagnose or treat an illness. Medicare covers certain clinical research studies and may help pay for some of the costs for study participants.
3. Are you entitled to benefits through the Department of Veteran's Affairs (DVA)?
   - Having both Medicare and VA benefits greatly widens coverage. VA coverage pays for medical services if the patient goes to a VA hospital or doctor or is approved for care in our organization. With Medicare, the patient may have additional coverage when going to a non-VA provider.
4. Was the illness/injury due to a work-related accident/condition?
   - Answering Yes populates additional questions to determine if another payer may be responsible.

Part I
1. Are you receiving Black Lung (BL) benefits? Yes No
2. Are these services to be paid by a government research program? Yes No
3. Are you entitled to benefits through the Department of Veterans Affairs (DVA)? Yes No
4. Was the illness/injury due to a work-related accident/condition? Yes No

Part II

1. Was the illness/injury due to a non-work-related accident?
   a. Answering Yes populates additional questions to determine if another payer may be responsible.
   b. Make sure you understand the questions on the MSPQ. If a patient presents with face lacerations and a fractured femur that occurred from a fall injury at a friend's home, he or she will probably answer "No" if asked "Did you have an accident?". The patient may not realize injuries that occur in someone's home are covered by homeowner's insurance.

Part II
1. Was the illness/injury due to a non-work-related accident? Yes No
Date of accident
2. Is no-fault insurance available?* Yes No
* No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident.
3. Is liability insurance available?** Yes No
** Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property.

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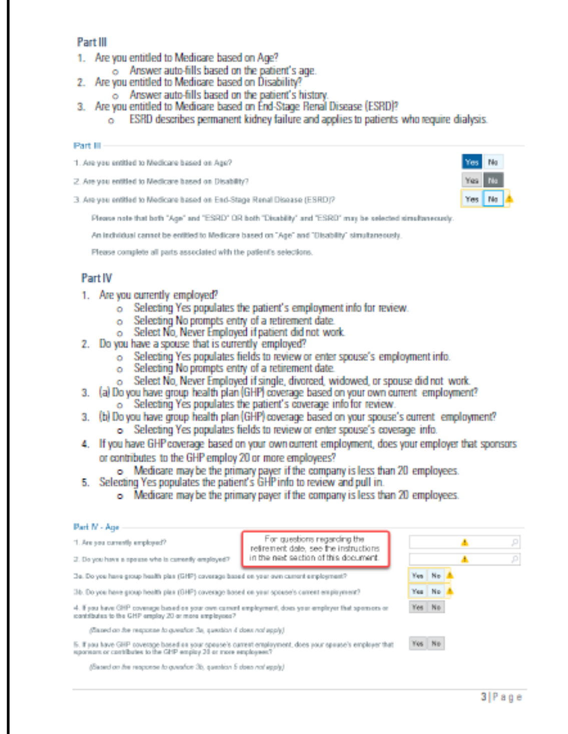

Part III

1. Are you entitled to Medicare based on Age?
   - Answer auto-fills based on the patient's age.
2. Are you entitled to Medicare based on Disability?
   - Answer auto-fills based on the patient's history.
3. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)?
   - ESRD describes permanent kidney failure and applies to patients who require dialysis.

Part III
1. Are you entitled to Medicare based on Age? Yes No
2. Are you entitled to Medicare based on Disability? Yes No
3. Are you entitled to Medicare based on End-Stage Renal Disease (ESRD)? Yes No
Please note that both "Age" and "ESRD" OR both "Disability" and "ESRD" may be selected simultaneously.
An individual cannot be entitled to Medicare based on "Age" and "Disability" simultaneously.
Please complete all parts associated with the patient's selections.

Part IV

1. Are you currently employed?
   - Selecting Yes populates the patient's employment info for review.
   - Selecting No prompts entry of a retirement date.
   - Select No, Never Employed if patient did not work.
2. Do you have a spouse that is currently employed?
   - Selecting Yes populates fields to review or enter spouse's employment info.
   - Selecting No prompts entry of a retirement date.
   - Select No, Never Employed if single, divorced, widowed, or spouse did not work.
3. (a) Do you have group health plan (GHP) coverage based on your own current employment?
   - Selecting Yes populates the patient's coverage info for review.
3. (b) Do you have group health plan (GHP) coverage based on your spouse's current employment?
   - Selecting Yes populates fields to review or enter spouse's coverage info.
4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees?
   - Medicare may be the primary payer if the company is less than 20 employees.
5. Selecting Yes populates the patient's GHP info to review and pull in.
   - Medicare may be the primary payer if the company is less than 20 employees.

Part IV - Age
1. Are you currently employed?
2. Do you have a spouse who is currently employed?
For questions regarding the retirement date, see the instructions in the next section of this document.
3a. Do you have group health plan (GHP) coverage based on your own current employment? Yes No
3b. Do you have group health plan (GHP) coverage based on your spouse's current employment? Yes No
4. If you have GHP coverage based on your own current employment, does your employer that sponsors or contributes to the GHP employ 20 or more employees? Yes No
(Based on the response to question 3a, question 4 does not apply)
5. If you have GHP coverage based on your spouse's current employment, does your spouse's employer that sponsors or contributes to the GHP employ 20 or more employees? Yes No
(Based on the response to question 3b, question 5 does not apply)

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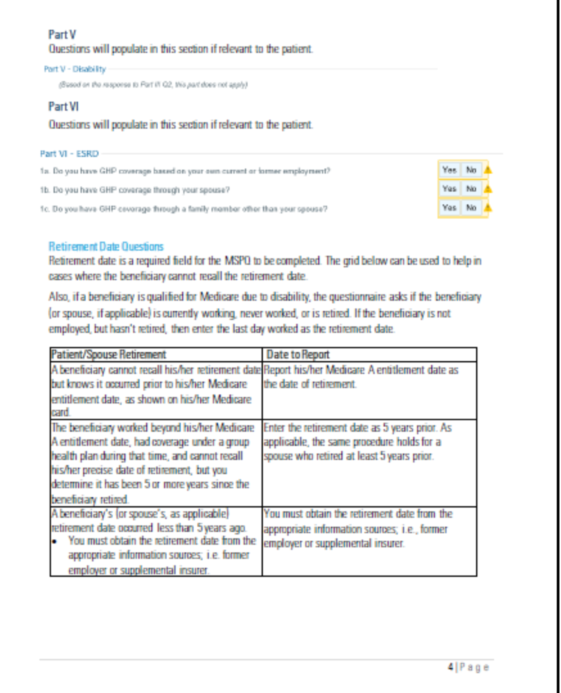

Part V

Questions will populate in this section if relevant to the patient.

Part V - Disability
(Based on the response to Part III Q2, this part does not apply)

Part VI

Questions will populate in this section if relevant to the patient.

Part VI - ESRD
1a. Do you have GHP coverage based on your own current or former employment? Yes No
1b. Do you have GHP coverage through your spouse? Yes No
1c. Do you have GHP coverage through a family member other than your spouse? Yes No

Retirement Date Questions

Retirement date is a required field for the MSPQ to be completed. The grid below can be used to help in cases where the beneficiary cannot recall the retirement date.

Also, if a beneficiary is qualified for Medicare due to disability, the questionnaire asks if the beneficiary (or spouse, if applicable) is currently working, never worked, or is retired. If the beneficiary is not employed, but hasn't retired, then enter the last day worked as the retirement date.

Patient/Spouse Retirement	Date to Report
A beneficiary cannot recall his/her retirement date but knows it occurred prior to his/her Medicare entitlement date, as shown on his/her Medicare card.	Report his/her Medicare A entitlement date as the date of retirement.
The beneficiary worked beyond his/her Medicare A entitlement date, had coverage under a group health plan during that time, and cannot recall his/her precise date of retirement, but you determine it has been 5 or more years since the beneficiary retired.	Enter the retirement date as 5 years prior. As applicable, the same procedure holds for a spouse who retired at least 5 years prior.
A beneficiary's (or spouse's, as applicable) retirement date occurred less than 5 years ago. • You must obtain the retirement date from the appropriate information sources; i.e. former employer or supplemental insurer.	You must obtain the retirement date from the appropriate information sources; i.e., former employer or supplemental insurer.

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Patient Scheduling Checklist for Telehealth Visit

Patient Scheduling Checklist: Confirm Patient for Telehealth Visit

This checklist helps ensure patients are consistently screened for telehealth visits (two-way, interactive videoconferences that occur in real-time) based on clinical and technology/ connectivity criteria, and their interest in giving telehealth a try to promote safe and continued access to healthcare during the COVID-19 public health emergency (PHE). Complete the checklist during the telephone call to schedule patients' appointments. Clinic safety protocols will help you determine whether telephone or clinic visits are viable options for patients unable to be "seen" via telehealth using your videoconferencing platform (VCP).

☐ 1. Patient need aligns with "Criteria, Conditions and Appointment Types for Telehealth-Appropriate Encounters" or patient's provider has determined requested appointment is appropriate for telehealth.

☐ 2. Confirm patient received and reviewed letter/inserts describing transition to telehealth for the duration of the COVID-19 public health emergency.
   a. Answer any questions and address patient concerns

☐ 3. Patient has access to a computer, tablet and/or smartphone.

☐ 4. Patient has means to connect via WIFI or an appropriate amount of data on their cell phone to avoid extra charges to their monthly bill (such as an unlimited data plan).

☐ 5. Patient wishes to proceed with a telehealth visit with their provider.

☐ 6. Confirm the phone number the patient would like the provider to use to re-establish contact in the case of a videoconferencing difficulty. Explain to the patient that the **provider will reach out to the patient** if the video connection is lost during a visit.

☐ 7. Patient appointment scheduled 30 minutes prior to their encounter with their provider.

☐ 8. Complete registration.
   a. Verify demos.
   b. Verify insurance/complete MPSQ/confirm co-pay will be billed (if applies).

Patient Telephone Confirmation Checklist: Preparing for a Successful Telehealth Visit

This checklist is completed when the telephone call is placed to confirm the patient's telehealth appointment. The goal is to ensure the patient is prepared, and confident they'll have a successful telehealth visit with their provider. The confirmation call is recommended 24-48 hours prior to the patient's appointment.

☐ 1. Confirm the patient received an email with the date and time they were scheduled, and are planning to complete the visit.
   a. Confirm they also received the instructions for downloading your VCP and a link or meeting ID to log into the VCP the day of their appointment.
   b. If the patient has not yet downloaded the VCP software, assist the patient to complete this step

☐ 2. Complete a test meeting successfully with the patient, and reinforce this is exactly what they'll need to do the day of their appointment.
   a. Confirm that their appointment is scheduled to begin 30 minutes prior to the encounter with their provider to ensure all connection and/or technology issues are resolved prior to when their provider logs in.

☐ 3. Confirm the phone number the patient would like the provider to use to re-establish contact if technology or connectivity challenges prohibit the visit from being completed on your VCP.
   a. Ask the patient to keep their phone with that number nearby the day of their visit.
   b. Remind the patient that the **provider will reach out to the patient** if the video connection is lost during the visit.

☐ 4. Communicate the expectations to the patient for during the visit.
   a. A private and quiet area in the home with limited distractions and clear of power cords is ideal.

☐ 5. Confirm the patient's vitals will be collected prior to the appointment if possible on the day of their appointment – another step completed prior to the encounter with their provider.
   a. Let patient know this is not a requirement if they do not have the tools needed.
   b. Vital signs that might be reportable by patients from home include:
      - Temperature (note type of thermometer used)
      - Blood pressure (note type of BP cuff used and proper protocol followed)
      - O2 level oximetry (pulse oximeter)
      - Pulse (manual wrist counting for 30seconds, smart watch, phone app, pulse oximeter)
      - Height and weight
      - Other Smartwatch and activity data

Patient Appointment Day Checklist: Complete a Successful Telehealth Visit

This checklist is completed the day of the patient's scheduled appointment and helps the patient complete a successful telehealth visit on your videoconferencing platform. Remember this appointment is scheduled to begin 30 minutes prior to when their provider logs in for the patient's encounter.

☐ 1. Admit the patient to the meeting/appointment scheduled on the VCP.
   a. If the patient is unable to log in, troubleshoot to find an alternative that works.
   b. This time is to ensure the patient can log in and everything below is complete so they are prepared for their telehealth encounter with their provider.

☐ 2. Confirm the patient's identity.

☐ 3. Complete outstanding registration information and confirm patient will be billed for their co-pay (if applies).

☐ 4. Confirm the phone number the patient would like the provider to use to re-establish contact if technology or connectivity challenges prohibit the visit from being completed on your VCP.
   a. Ask the patient to keep their phone with that number nearby.
   b. Remind the patient that the **provider will reach out to the patient** if the video connection is lost during the visit.

☐ 5. Collect and document patient's verbal consent to participate in the telehealth visit.

☐ 6. Communicate the expectations to the patient for during the visit.
   a. A private and quiet area in the home with limited distractions and clear of power cords is ideal.

☐ 7. Complete rooming workflow.

☐ 8. Collect patient's vitals prior to the appointment if possible and complete meds review.
   a. Let patient know this is not a requirement if they do not have the tools needed.
   b. Vital signs that might be reportable by patients from home include:
      - Temperature (note type of thermometer used)
      - Blood pressure (note type of BP cuff used and proper protocol followed)
      - O2 level oximetry (pulse oximeter)
      - Pulse (manual wrist counting for 30seconds, smart watch, phone app, pulse oximeter)
      - Height and weight
      - Other Smartwatch and activity data