STAKEHOLDER QUESTIONS AND ANSWERS

This document contains answers to questions posed by stakeholders in the July 29 kick-off webinar. Answers provided are reflect information that is current as of October 1, 2020. Additional information from other stakeholder engagements will be added.

If you have questions that are not answered here, you may:

- Check the Provider Billing Manuals, including the Telemedicine Billing Manual
- Review information on the Telemedicine – Provider Information web page, or
- Submit the question on the Telemedicine & eConsults Stakeholder Feedback, Questions, Comments form

Telephone only (audio only) telemedicine

1. What constitutes a telephone only or audio only synchronous visit?
    a. A synchronous visit is when the patient and provider are speaking to each other on the telephone.
2. Is audio only a permanently approved telemedicine modality?
    a. The Centers for Medicare and Medicaid Services (CMS) has approved the State Plan Amendment affirming the provisions of SB20-212, including the use of audio only telemedicine visits.
3. Is it permissible to use the audio-only function of a HIPAA compliant audio-visual platform?
    a. Yes
4. How long will the HIPAA waiver for telephone only communication be extended?
    a. It is unknown at this time. The best action is to closely monitor Office of Civil Rights (OCR) statements on HIPAA compliance.
5. If telephone communication is deemed not HIPAA compliant, would that jeopardize how clinics communicate with patients in non-telemedicine situations? (E.g. appointment reminders, calling patients to notify them of lab/imaging results)
    a. The OCR is responsible for HIPAA compliance and will provide direction if telephone is deemed not HIPAA compliant.
6. Is a telephone only telemedicine visit reimbursed at the same rate as an audio-visual televideo visit for all providers including FQHC's?
    a. Yes.
7. How can organizations advocate for continued coverage for telephone-only visits, especially for those members who face technology access issues?
    a. The Department is assessing its telemedicine policies as they relate to access as well as quality, equity, and the state's budget. It is desirable to ensure equitable access for all members. However, the Department will be bound by federal regulations. See #2 above.

Reimbursement and code questions

8. How are claims for facility reimbursement for the originating site fee paid??
    a. Colorado Medicaid is reimbursing providers for Q3014 claims. Note the allowed provider types listed in the Telemedicine Billing Manual for originating site fee (Q3014).
9. Please explain Home Health and Hospice reimbursements for telephone visits.

    a. Home Health and Hospice visits are able to bill for telephone visits, but the visit is still required to meet the same standard of care as an in-person visit, therefore, not all services available under Home Health and Hospice can be provided via telemedicine (e.g. CNA assistance with skilled bathing needs).
10. What will be the plan for continuing H0005 and H0015 via telehealth?
    a. The Department is currently developing a response to this question.
11. In some states, a follow-up visit is not charged additional monies. This is accomplished by billing a 1 cent follow-up visit using CPT 99024 CR modifier. Can this be considered here?
    a. CPT 99024 is not a covered service. As noted in the Medical-Surgical Billing Manual, "Payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon. The post-operative period for each surgical procedure code is determined by the value given in the MPFSDB, and is either 0, 10, or 90 days. Evaluation and management services rendered by the surgeon during this period that are related to the original surgery are included in the payment for the surgery, and not separately reimbursable. The two procedures are considered to be related when the first three digits of the diagnoses are the same. Modifiers for reporting separately identifiable services during the postoperative period are described at the end of this manual."
12. Will EMS be considered for 911 treatment in place with a qualified healthcare provider or telehealth reimbursement?
    a. There are no direct reimbursements for treatment in place for EMS dispatched by 911 at this time. The Department is working with EMS providers associated with the Emergency Triage, Treat, and Transport (ET3) innovation model and EMS agencies are encouraged to engage even if they are not direct participants.
13. How can telemedicine be used in an urgent care setting and what is the reimbursement related to that?
    a. Providers at urgent care centers may render telemedicine. Allowed CPTs are listed on the Telemedicine – Provider Information web page. If the urgent care is an off-campus location of a hospital, please note that since the hospital facility is not being used, an institutional claim for the facility should not be submitted for telemedicine services.
14. What Family Therapy service codes are allowed for Telemedicine in mental health services?
    a. The CPTs for mental health family therapy are listed as allowed for telemedicine on the Telemedicine – Provider Information web page.

Regional Accountable Entities and telemedicine

15. Will RAES to adhere to the provisions of SB20 -212?
    a. The Department is currently developing a response to this question.

Dentistry

While the scope and extent of SB20-212 was the decision of the Colorado State Legislature, the Department appreciates all the feedback it received from the dental community during the 7/29 Stakeholder Kick-off webinar. The Department currently allows for coverage of dental emergencies via teledentistry, and we will consider the expansion of teledentistry when the current budget situation improves. In the meantime, we will continue to listen to stakeholder feedback and monitor what is happening in the dental community on a state and federal level.

Data Questions / Comments

16. How will the Department look at behavioral health utilization since you do not have claims for the managed benefits? Will that be looked at via the provider level data, RAE level, both?
    a. The Department receives limited behavioral health encounter data but it has not yet determined how it will analyze this data with regards to telemedicine.
17. Can you add other benefit category - dental? 9995 or 9996)
    a. The Department will take this suggestion under consideration. Due to known issues around dental data in our data system, analyzing dental telemedicine services is difficult.
18. Would the Department be able provide detail on different provider types such as dentist or optometrist in the dataset?
    a. The Department will take this suggestion under consideration. Please refer to the response in Question #21 regarding dental services.
19. Can the data be divided by age groups of "under 65" and "65+", rather than "60-69"? Also, can you show disaggregated data on race/ethnicity to address equity.
    a. The Department will take this suggestion under consideration.
20. Will there be any interactive components to the posted data?
    a. We are unable to post an interactive dashboard on our website due to HIPAA concerns and technological constraints.
21. Our agency converted to telemedicine overnight and didn't have gaps in service for behavioral health provided through a RAE. I don't see this reflected in the data
    a. Only Fee for Service Medicaid claims are included in this data. We have not posted behavioral health encounter telemedicine data at this time.
22. Do we have any data showing that telemedicine reduced ER utilization?
    a. We have seen reduced ER utilization during the pandemic; however, it is difficult to determine whether this decrease is due to COVID-19 stay-at-home efforts, telemedicine increases, other factors, or a combination of these.
23. Why is there a weekly spike for the first week of every month?
    a. The weekly spike occurring the first week of every month is likely due to span billing.
24. Diabetes education is an allowed service but not shown on the data slides. Is this because the numbers are so low?
    a. Yes, only the top codes are shown in the data slides.
25. Seeing this data for CMHCs would be appreciated.
    a. The Department will take this suggestion under consideration.

+Other Questions

26. Are there any updates on moving from direct supervision requirements to general supervision requirements for health education services delivered via telemedicine?
    a. The rule change is in process to allow general supervision of health education services. The process was interrupted but is being resumed. If the rule change is approved there will be a notice in the provider bulletin.

27. Can a provider see a patient from out of state for the initial evaluation via telemedicine?
    a. Colorado Medicaid does not cover patients that live out of state.
28. Can a provider have a license to practice in Colorado and move to another state and provide telemedicine services to Colorado Medicaid patients from the provider's out-of-state location?
    b. Yes. Appropriately enrolled providers located out-of-state may provide telemedicine services to Health First Colorado members.
29. Is there any discussion of opening Remote Patient Monitoring to individual provider practices?
    c. The Department will review coverage of 99457 and 99458, remote physiologic monitoring treatment management services. If the services are added, there will be a provider bulletin article and a rate included on the fee schedule.
30. Is there any discussion of joining CMS in supporting the Emergency Triage, Treat, and Transport (ET3) program and allow EMS agencies to conduct telehealth encounters from a patient's site rather than transport the patient to a more expensive venue?
    d. The Department is working with EMS providers associated with the Emergency Triage, Treat, and Transport (ET3) innovation model and EMS agencies are encouraged to engage even if they are not direct participants. EMS agencies are also allowed to transport patients to alternate locations for more appropriate care.
31. Is Electronic Visit Verification required for outpatient Occupational Therapists (OTs) who are providing telemedicine rather than seeing clients in the clinic?
    e. EVV is required for outpatient OTs that provide services via telemedicine. The EVV Compliance Timeline is addressed specifically in Operational Memo 20-079. Please contact the EVV program directly with questions: evv@state.co.us. EVV specific guidance for telehealth is also available on the EVV website.
32. How will the PAR system adjust for situations where a provider needs to see a child both in person and via telehealth?
    f. For Prior Authorization Requests, providers should leave the Place of Service field blank. This will prevent a claim from denying if the Place of Service field does not match the PAR. PAR documentation must still indicate the places the member will receive services.
33. Live chat technological infrastructure can be costly. Is there any discussion of allowing asynchronous chat?
    g. The Department will review the telemedicine policy. The review will address all areas of telemedicine for appropriate coverage.
34. As an independent, outpatient SUD treatment provider specialist the technology that could support our clinicians talking with our primary care partners would be important, but barely available/affordable. What are your technology plans to bridge the gap in those practice models?
    h. Answer: The Department will consider this question as it assesses its telemedicine policies.
35. While we have good data on implementation, will this group also be looking at quality metrics and how those change due to the COVID-19?
    i. The Department is looking at available quality metrics as it assesses its telemedicine policies.
36. I'm curious to hear what the Department learns from evaluating outcomes.

j. The Department's SMART Act Hearing will include a report on its policy assessment including the evaluation of outcomes. SMART Act Hearing materials can be found on the Department's Legislator Resource Center webpage

37. I would like to know more about your hypotheses on lack of rural uptake.
    k. See #36
38. What are the distinctions between what the state can decide and implement and where there are federal influences/decisions (i.e. HCBS waivers)?
    l. All services provided through Colorado Medicaid are subject to federal influences and decisions. Non-waiver services provided through Colorado Medicaid to its Health First Colorado members are authorized by the Department's State Plan which is approved by CMS. Those services are subject to Rules as authorized by the Medical Services Board and also policy created by the Department. All three authorizations - State Plan, Rules, and policy - must be in alignment. Health First Colorado members are subject to the same eligibility criteria, and services are provided based on medical necessity. Waiver services are provided through a separate approval process from CMS and must also conform to Rules and policy. The key difference is that waiver services each have different eligibility criteria and a narrow scope of services.
39. Does telemedicine require to have Hubstaff to monitor provider work from home?
    m. No.
40. Can a single provider, primary care office get start-up funding?
    n. The Department does not provide start-up funding to providers.