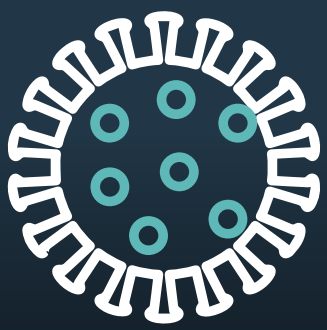
Thursday, March 26, 2020

WellSky

The WellSky **COVID-19** update for senior living providers



by **Donna Doneski**
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Understanding the loosening of regulations amid COVID-19

Telehealth in long-term care facilities

Background: telehealth and Medicare

Historically, Medicare has paid for a limited number of Part B services carried out by a physician or practitioner to an eligible beneficiary through telecommunication services. Medicare beneficiaries have traditionally been eligible for telehealth services only if the services are provided from an "originating site," such as a nursing home by a practitioner at a distant site. Nursing facilities must generally be located in a rural area to utilize telehealth, and only certain practitioners are able to utilize telehealth.

> **Originating site:** The location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs.

The Centers for Medicare & Medicaid Services (CMS) has approved a small number of practitioners who can receive payment for Part B covered telehealth services, including doctors, nurse practitioners and others. This is also subjected to state law. Currently, physical therapists, occupational therapists, and speech language pathologists are not included in the list of eligible telehealth practitioners.

The National Association for the Support of Long Term Care (NASL) is advocating for Congress to add rehabilitation therapists to the list of those who can furnish and receive payment for covered telehealth services.

The §1135 waiver for telemedicine

On March 6, CMS broadened access to Medicare telehealth services via an §1135 waiver. The waiver is expected to last for the duration of the COVID-19 Public Health Emergency. Under this waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth. The goal of this waiver is to help ensure Medicare beneficiaries, who are at a higher risk of COVID-19, can visit with their doctor from home or without having to go to a doctor's office or hospital. Under the §1135 waiver, telehealth services will be offered outside of rural settings and originating sites. For nursing home providers, this means nursing facilities in all areas of the country, not only rural areas, can use telehealth under the waiver.

To utilize telehealth services, the patient must have a prior, established relationship with the practitioner. However, the Department of Health and Human Services (HHS) will not conduct audits to ensure a prior relationship existed for claims submitted during this public health emergency.

Providers should be aware that CMS' waiver allows for greater use of telehealth and other telecommunications:

- **Medicare telehealth visits:** a visit with a provider that uses telecommunication systems between a provider and a patient. Under this public health emergency, this service is available for new or established patients.
- **Virtual check-in:** a brief (5-10 minute) check-in with a practitioner via telephone or other telecommunications to decide whether an office visit or additional services are needed. This can include a remote evaluation of recorded videos and images submitted by the patient. This service is for established patients only.
- **E-visits:** communication between a patient and their provider through an online patient portal. This service is for established patients only.

Each service can be different Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Technology (CPT) codes. For a complete list of codes, consult CMS' telehealth codes resource.

What is a §1135 Waiver?

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act, and the HHS Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to temporarily waive, or modify, certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements.

These temporary changes are intended to ensure that sufficient health care items and services are available to meet the needs of Medicare and Medicaid beneficiaries under the Social Security Act. These waivers, which can be found under Section 1135 of the Social Security Act, typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless the Secretary of HHS issues an extension.

Health Insurance Portability and Accountability Act (HIPAA) considerations

To assist providers in delivering telehealth services, the HHS Office for Civil Rights (OCR) will loosen enforcement and waive penalties for HIPAA violations against healthcare providers that serve patients in good faith through everyday communications technologies. This will enable providers to provide telehealth services through technologies such as FaceTime, Skype, Zoom, and more during the COVID-19 public health emergency.

Ideally, providers should continue to use HIPAA-compliant technologies whenever possible.

Extended deadlines for Quality Reporting Program

On Sunday, March 22, CMS announced it would be granting exceptions from reporting requirements and providing extensions for clinicians and providers participating in Medicare quality reporting programs. Programs with extensions include:

- Long Term Care Hospital Quality Reporting Program
- Skilled Nursing Facility Quality Reporting Program
- Skilled Nursing Facility Value-Based Purchasing Program

Under this exception, no data reflecting services provided between January 1, 2020, through June 30, 2020, will be used in CMS' calculations for the Medicare quality reporting and value-based purchasing programs. The intent behind this change is to reduce the data collection and reporting burden on providers as they respond to the COVID-19 emergency.

Monitoring COVID-19 ICD-10 coding updates

Given the severity of the COVID-19 pandemic, the Centers for Disease Control & Prevention (CDC), under the National Emergencies Act Section 01 and 301, is announcing a change in the effective date of the new COVID-19 diagnosis code. This change will move the release date up from October 1, 2020, to April 1, 2020. This is an unprecedented, off-cycle update.

CMS has several documents available for providers to address coding and billing for COVID-19, including laboratory diagnostic services, physician services, and hospital services. These updates include ICD-10 codes and HCPCS codes.

The disaster relief (DR) condition code and COVID-19

What is a DR condition code?

A DR condition code is intended for use by providers, not by physicians and other suppliers, in billing situations related to a declared emergency or disaster. Since August 31, 2009, the use of a DR condition code has been mandatory for any claim for which Medicare payment is conditioned on the presence of a "formal waiver."

What does it mean if there is a DR condition code on a claim?

One of the biggest misconceptions about the DR condition code, as it relates to COVID-19, is providers believe the modifier can only be used if the patient has tested positive. This is not the case. Skilled nursing facilities (SNFs) can use the DR condition code to indicate waiver of the Medicare 3-day qualifying stay requirement. It also can be used to authorize renewed SNF coverage without having to start a new benefit period.

These changes acknowledge how the entire health system works together in a time of crisis. Each patient is part of the larger health system, which is in dire need of bed space.

What loosened regulations mean

Providers cannot and should not expect these loosened restrictions to stay in place forever. Facilities must put measures in place to monitor how these programs are being used and continue to monitor their status.

To do this, consider these tips:

- Monitor facility bandwidth to ensure telemedicine services are enabling your clinical team is delivering high-quality care, and that telecommunication use is not impeding services being offered within your facility.
- When conducting a telemedicine service, continue to document in a way that ensures Medicare compliance, including key areas such as time in, time out, and what the care team assessed. While services are being carried out virtually, standard protocols for entering notes must remain the same to ensure Medicare Part B reimbursement.
- Use your in-facility team to assist your virtual care team when possible. When possible, have an in-facility team member assist with vital signs to help the virtual practitioner be as accurate as possible.
- Whenever you deviate from a normal process to follow a loosened regulation, make a note to revisit the change at a set increment of time. This will ensure processes return to normal as the public health emergency begins to ramp down.

About the author

Donna Doneski serves as liaison to NASL's IT Committee and represents NASL in its work with ONC, CMS, CDC, NCPDP and the LTPAC Health IT Collaborative. Her two decades of experience in national healthcare and health IT policy includes issues advocacy, grassroots outreach, crisis communications, and coalition building. She is staff liaison to the NASL IT Committee, which focuses on interoperability and issues representing the intersection of clinical, diagnostic testing & health IT. She was the Director of Public Affairs for the American Health Care Association (AHCA), where she was liaison to the Pharmacy Quality Alliance (PQA) and Advancing Excellence in America's Nursing Homes. Donna also directed media and external communications for a national patient advocacy organization working directly with HBO® and producer, Joseph Lovett, on the Emmy-nominated, Peabody-award-winning documentary and accompanying website, Cancer: Evolution to Revolution.

About NASL

National Association for the Support of Long Term Care

Insight • Advocacy • Action

The National Association for the Support of Long-Term Care (NASL) is a trade association representing the federal legislative & regulatory interests of ancillary services and providers working in the long term and post-acute care (LTPAC) sector. NASL members include rehabilitation therapy companies that provide physical, occupational and speech-language pathology therapies; vendors of health information technology that develop and distribute full clinical and electronic medical records, billing and point-of-care IT systems and other software solutions that serve the majority of LTPAC providers; portable x-ray and lab services and products such as complex medical equipment and additional specialized supplies for long-term and post-acute care settings nationally.

NASL advocates for high-quality care by advancing legislative and regulatory policy that enables its members to best care for the patients they serve.

WellSky

WellSky Long-Term Care

WellSky Long-Term Care is the industry's most intuitive and comprehensive clinical and billing system. Our easy-to-use software turns data into actionable insights that increase efficiency, ensure resident safety, and support profitability for long-term care facilities.

The views, information, and guidance in this resource are provided by the author, and they do not necessarily reflect those of WellSky.