To the Pandemic and Beyond!

Achieving and Sustaining Compliance for Your Telehealth Program

Presented by Laura Hepp Kessel and Kate Cohen

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Speakers

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- JD, CHRC, CHC
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- MSW
- Experience in building healthcare partnerships, community outreach/organizing, rural healthcare and state government.

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Objectives

- Identify compliance risks in telehealth programs, both during the pandemic and beyond
- Discuss assessing and planning for long term compliance within a changing regulatory landscape
- Identify best practices for a successful proactive partnership between telehealth and compliance

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Let's Speak the Same Language!

Pre-pandemic: prior to March 2020

Originating site: location of the patient

Distant site: location of the healthcare provider

PHE: public health emergency

Traditional telehealth: We will use this term to refer to a telehealth scenario where the patient is located at an originating site and the provider is located at a distant site when both originating site and distant site meet the requirements established under the traditional pre-pandemic telehealth billing rules.

Telehealth to the Home = Direct to Consumer

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Pre-Pandemic Rules

- Originating site had to meet the following conditions:
  - Located within a Health Professional Shortage Area
  - One of the following types of facilities
    - Physicians or practitioner offices
    - Hospitals (including critical access hospitals)
    - Rural health clinics
    - Federally Qualified Health Center (FQHC)
    - Hospital based or CAH based Renal Dialysis Center
    - Skilled Nursing Facilities
    - Community Mental Health Centers

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Pre-Pandemic Rules

- FQHCs and RHCs were not permitted to serve as distant site providers under CMS rules.
- Some states (such as Illinois) allowed FQHCs and RHCs to provide and receive reimbursement from Medicaid for distant site services.

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Telehealth and Compliance Programs at SIU Medicine

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Pre-Pandemic State

- Compliance and telehealth offices in a state of re-building
- Both offices had been without leadership for extended periods of time
- Limited telehealth expertise in the compliance office
  - Lack of auditing and monitoring for telehealth billing
- Telehealth program was primarily focused on distant site services for smaller facilities in the surrounding rural areas
  - Primarily dermatology, endocrinology (more specifically diabetes management), psychiatry, pulmonology, genetics and MFM.
  - Less than 2,000 telehealth visits in CY2019
  - Limited primarily to places where SIU had a contractual relationship with the other entity and where SIU owned equipment that was leased by the originating site to facilitate the visit. Some additional telehealth offered through agreements with correctional facilities (state prisons and county jails) and other special populations.

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Pre-Pandemic State

- February 2020: Compliance and Telehealth started meeting to discuss increased collaboration and increased participation of compliance in telehealth expansion.
- February 2020: Telehealth identified a need for compliance review of telehealth bills and billing practices to ensure appropriate identification of telehealth services.

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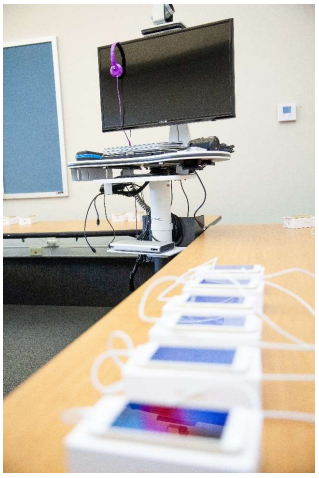
Current State

- SIU performed more than 63,000 telehealth visits in CY2020 (compared to less than 2,000 the year prior)
- Active, collaborative partnership between compliance and telehealth
- Rapid expansion of SIU's telehealth program and partnerships across the state
- Software and equipment investments to optimize and further expand telehealth options throughout the PHE and after



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Compliance Risks in a Telehealth Program

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Billing Risks

- Pre-pandemic billing rules for telehealth were somewhat complicated and could be impacted by the types of relationships you set up with telehealth partners
  - Originating and distant site requirements
  - Both submit a bill
  - Frequency limitations that varied depending on facility (inpatient, outpatient, nursing home)
  - Differences between payers

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Billing Risks

- In the early months of the pandemic, the rules were changing rapidly. Organizations interpreted the new rules differently.
- Payer memos, media headlines and mass emails/advocacy by professional associations created significant confusion which in some cases led to providers ignoring compliance advice on billing and following a misleading headline or information from a blast email received
- De-centralized coding created a significant education barrier for compliance as the rules continuously changed

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Billing Risks

- EMR was not set up with note templates for telehealth and during the first 30 days of rapid telehealth deployment across the organization, the note template changed multiple times.
- Culture of hyper customization of note templates by department created a need to balance valuable feedback from providers in real time as they used the notes with department desires to have a note specific to telehealth visits for each type of visit and each type of provider.

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Billing Risks

- Organizations struggled with the need to capture revenue as in person visits stopped entirely or significantly declined with the desire to hold telehealth charges until billing rules were clarified and/or updated.
- In the early months of the pandemic, providers were asked to consider the patient's insurance provider before deciding what type of visit (audio only or audio/video) the patient could be scheduled for
  - State rules allowed for Medicaid and commercial payer patients to be seen for telehealth without a video component while Medicare required the video component for telehealth services.
  - Providers weren't accustomed to tracking patient's insurance when treating or developing a treatment plan.

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Billing Risks

- New patient registration/paperwork for telehealth visits
- Balancing requirement to have video component for billing purposes vs. the physician's medical judgment of whether they needed to visually see the patient
- Patients misconception that telehealth visits weren't "a real visit" and wouldn't/shouldn't be charged for them
- Billing provider location while supervising residents
- Keeping up with PHE extensions at both the federal and state level (90 vs. 30 day extensions)

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Privacy and Security Risks

- Like many organizations without an existing robust telehealth program, SIU had to figure out how to deploy telehealth across the enterprise within a matter of days.
- SIU had an existing license and BAA with Webex and quickly started rolling out telehealth appointments via the Webex platform.
- Providers had challenges using Webex in the beginning as did patients. Providers started looking for other options.

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Privacy and Security Risks

- While there was a certain degree of OCR enforcement discretion surrounding the use of telehealth platforms, some took that to mean "we don't have to follow HIPAA anymore!" and the compliance office and the telehealth office had to collaborate to address this issue.
  - Confusion around regulatory requirements and enforcement discretion
  - Dissatisfaction with telehealth technology options
- Joint guidance issued from compliance, telehealth and IT related to the use of Webex and the other acceptable options for telehealth visits.

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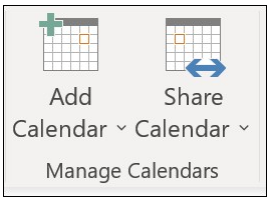
Privacy and Security Risks

- Scheduling was an early challenge
  - Webex invites had to be sent to email addresses
  - Emails entered incorrectly or sent to the wrong patient
- Prior privacy rule that no names or initials could be in calendar invites. Internal “breach” reports made on a regular basis.
- Dual schedules maintained – one in our regular scheduling system and the other on the provider’s calendar or a newly created shared calendar for telehealth by dept./division/clinic to accommodate the Webex calendar invite



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Privacy and Security Risks

- Other scheduling challenges
  - Patients receiving telehealth email invitations with provider emails also included- concern from providers about increased email communication from patients
  - Staff working from home – need for call masking technology to avoid patients having a provider or staff member’s personal cell phone number
  - Providers using FaceTime to communicate with patients – the provider’s phone number or email was required to make those FaceTime calls and was then visible to patients
- Reverse telehealth: providers quarantined at home with patients in clinic rooms that aren’t equipped for these telehealth appointments

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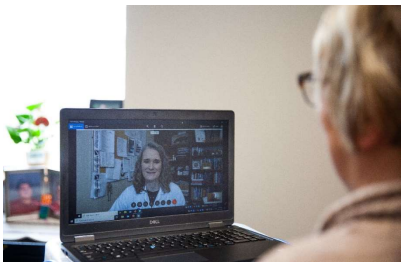
Privacy and Security Risks

- Providers need private spaces during telehealth visits and/or needed a headset, ear buds, etc.
- Patient privacy concerns
  - What is the organization's obligation to educate patient on privacy risks?
  - PHI in telehealth appointment emails?
  - Provider and/or dept./division/clinic information in telehealth appointment email?
  - Is the patient's home environment private and safe for the telehealth appointment?



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Licensing Risks

- Once telehealth became more widespread across the organization, we saw a handful of cases of providers seeing patients who were not located in the state of Illinois.
- Providers wondered whether they could be located out of state while providing telehealth.
- Confusion about billing rules vs. state licensing rules.
- Some geographic considerations for our outlying clinics that we had not thought about during the scramble to get telehealth deployed across the enterprise.
- Post pandemic plan for telehealth across state lines.

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Other Risks

- Adjusting existing clinic policies regarding no shows, patient terminations, etc.
- Difficulty incorporating language and ASL interpreters in to telehealth appointments. (ADA, Section 1557 of ACA)
- Providers not comfortable seeing patients via telehealth and distressed over this option when the organization wasn't requiring all patients to be seen via telehealth

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Credentialing Challenges

- For traditional telehealth set ups with partner hospitals, we ran into a conflict between our by proxy credentialing process and Joint Commission rules
- Future traditional telehealth – how do we ensure providers are credentialed at the originating sites when required while balancing the internal challenges of not always knowing who is willing and available to provide telehealth services
  - Example – we know that we can commit to providing tele-derm services to a partner hospital, but we don't know which of our providers is willing to do telehealth services and if our provider schedules will match clinic availability with our partner. Available providers may change based on time, patient load and experience with telehealth. How do we cover the service without credentialing the entire department at the partner hospital?

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Planning for Long Term Compliance in Your Telehealth Program

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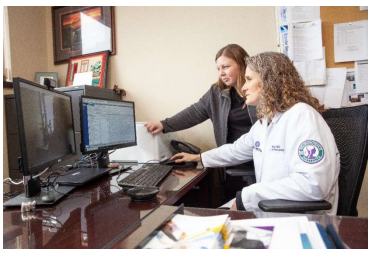
Compliance Tools for Billing Compliance



- Telehealth billing toolkits
- Education sessions
  - By department, virtual town halls
- One page resource documents related to individual topics
  - Examples: privacy for pandemic telehealth, “incident to” billing
- Keeping up with changing regulations
  - Compliance alerts
  - Join the listservs that your providers subscribe to!

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Long Term Planning

- Balance the need for traditional telehealth while keeping up with pandemic telehealth needs.
- Planning for differences among payers in long term coverage of pandemic telehealth (i.e. patient at home)
- Potential for the end of enforcement discretion from OCR once PHE expires – do you have software alternatives in place to ensure providers and patients don't fall back on other technology options used for telehealth that may no longer be allowed (i.e. Facetime)?

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Leadership Support

- Is telehealth a priority for your organization?
  - Financial and other resource investment in planning for the future of telehealth in a changing regulatory environment.
- Do you have leadership support for compliant telehealth practice?
  - Privacy risks in the search for alternative telehealth technology
  - Support for compliant billing practices despite the misleading information distributed

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Building and Maintaining a Successful Partnership

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Myth Busters!

- Keep each other informed about what you are hearing.
- If you are on the listservs that your providers subscribe to, prepare responses once you identify potentially misleading information.
- Approach questions from providers and staff by asking yourself… Does the other need to be copied or consulted? Show unity in messaging!

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Myth Busters!

- PHE confusion regarding free telehealth services vs. copays being waived… marketing myths
- Leverage each other's connections
  - What are other organizations in your area doing?
  - Are other organizations managing this differently than we are?

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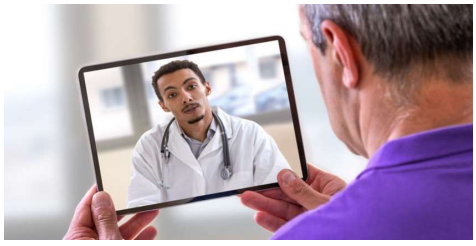
Telehealth Expansion

- For organizations that are using the pandemic to expand telehealth programs, the telehealth office needs compliance to participate in evaluating that expansion.
  - Technology platforms
  - Policies, procedures and guidelines
  - Billing compliance
  - Contract language
  - Overall feedback, suggestions and guidance!



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Communication is Key

- Regular meetings and as needed communication
- Compliance should keep the telehealth office informed about audit findings/trends
- Telehealth should share concerns or potential issues with compliance
- Talk about the telehealth program generally- there are compliance risks you might not think to identify as “risks”

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Other Suggestions?

Friends don’t let friends re-invent the wheel!

How are you fostering a collaborative relationship between telehealth and compliance?

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Questions?
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