Transforming Tobacco Cessation with Telehealth: How Behavioral Health Providers Can Promote Cessation with Technology

Thursday, May 14, 2020
12:00-1:30pm EST

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https://www.streamtext.net/player?event=TransformingTobaccoCessationwithTelehealth
Welcome!

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Project Manager, Practice Improvement
National Council for Behavioral Health

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Senior Director, Practice Improvement
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Today’s Presenters

Anne DiGiulio
National Director, Lung Health Policy
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Kimber P. Richter, PhD, MPH, NCTTP
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Department of Population Health
University of Kansas School of Medicine

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Smoking Cessation Education Coordinator
Upstate Medical University

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Business Office Manager
Upstate University Hospital
Housekeeping

- Webinar is being recorded. All participants placed in “listen-only” mode.
- For audio access, participants can either dial into the conference line or listen through your computer speakers.
- Submit questions by typing them into the chatbox.
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- Slide handouts and recording will be posted here:
  - [https://www.bhthechange.org/resources/resource-type/archived-webinars/](https://www.bhthechange.org/resources/resource-type/archived-webinars/)
Today’s Webinar

1. Background Information and Existing Resources
2. Overall Landscape and Policy Updates
3. Challenges and Opportunities
4. Lessons Learned from a Provider Perspective
5. Discussion/Q&A
Jointly funded by CDC’s Office on Smoking & Health & Division of Cancer Prevention & Control

Provides resources and tools to help organizations reduce tobacco use and cancer among people with mental illness and addictions

1 of 8 CDC National Networks to eliminate cancer and tobacco disparities in priority populations

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#BHtheChange
In 2018, Smoking Cessation Leadership Center (SCLC) was designated as the first Substance Abuse and Mental Health Services Administration's (SAMHSA) National Center of Excellence for Tobacco-Free Recovery (CTFR).

CTFR Goals:
• Promote the adoption of tobacco-free facilities, grounds, and policies
• Integrate evidence-based tobacco cessation treatment practices into behavioral health & primary care settings and programs
• Educate behavioral health and primary care providers on effective evidence-based tobacco cessation interventions

CTFR offers:
▪ Specialized subject matter expertise to provide training & technical assistance to states, local governments, tribal communities, behavioral health organizations, primary care providers, clinicians, peers, families, and other stakeholders to help reduce tobacco use among persons with behavioral health disorders.
▪ Builds on and expands SAMHSA’s efforts to increase awareness, disseminate current research, educate behavioral health providers, & create results-oriented collaborations.
Our Vision
A World Free of Lung Disease
Tobacco Use Disparities in MH/SUD Settings

What We Know:

- Individuals with mental health (MH) and substance use disorders (SUD) use tobacco at rates **2-4x higher** than the general population and have lower quit rates.¹

- On average, **less than 60%** of MH/SUD treatment facilities screened clients for tobacco use in 2018 and **only 42%** of MH/SUD treatment facilities had smoke-free campuses that same year²,³


Linkages Between Tobacco Use, BH & COVID-19

Smokers are approximately **1.4 times more likely** to have severe symptoms of COVID-19.⁴

Smokers are approximately **2.4 times more likely** to experience severe complications or death from COVID-19 compared to non-smokers.⁴

Other considerations
- Behavioral response to stress and anxiety
- Hand to mouth transmission by tobacco products

The Critical Role of Telemedicine

The good news is that 48% of behavioral health provider organizations already use telemedicine.5

The use of telehealth at can improve successful rates of tobacco cessation by reducing barriers to treatment such as distance, time constraints, and cost.

Federal guidelines have also been modified so that more practitioners may use telehealth during COVID-19.


National Council General Telehealth Resources

Access free resources at https://www.thenationalcouncil.org/covid19/
Telehealth and Tobacco: Leveraging Technology to Extend Tobacco Treatment
Resource Guide & Provider Toolkit

Available for free download at www.BHtheChange.org

Link to download document available in today’s webinar chatbox
The Landscape of Telehealth and Tobacco Cessation

Anne DiGiulio
National Director, Lung Health Policy

May 14, 2020
Overview

- Tobacco Cessation Benefit
- Why Telehealth?
- Current Telehealth Landscape
- Resources
Tobacco Cessation Benefit

Key Components of a Cessation Visit
Tobacco Cessation Coverage

Tobacco Cessation Treatments

• Medications
  • NRT Gum*
  • NRT Patch*
  • NRT Lozenge*
  • NRT Inhaler
  • NRT Nasal Spray
  • Bupropion
  • Varenicline

• Counseling
  • Individual
  • Group
  • Phone

* Available over-the-counter; need a prescription for no cost-sharing
Why Telehealth?
Why Telehealth?

Telehealth and COVID-19

1. Telehealth limits patient exposure to COVID-19 and allows them to access healthcare.

2. Telehealth protects providers and patients that require in-person care from being exposed to COVID-19.

3. Need to remember not everyone has access to technology and the broadband to use telehealth effectively and securely.
Current Telehealth Landscape
1135 Waivers

- Can waive or modify the Medicare, Medicaid or CHIP programs during a Disaster or Emergency declared by the President (under the Stafford Act) or during a Public Health Emergency declared by the Secretary of Health and Human Services (under the Public Health Services Act).

- Waivers only apply to federal requirements.

- Waivers last no longer than 60 days or the declared emergency or disaster.
Telehealth Landscape

What’s Changed in Medicare?

• **Modality**
  - OCR has enforcement discretion for providers not using HIPAA compliant technology
  - Some services can be provided audio-only (including 99406 and 99407)

• **Physical Locations**
  - The originating site requirements (for providers) have been waived
  - Patient allowed to be at home for appointment

• **Licensure**
  - Temporarily waived requirement that the provider needs to be licensed in the state the patient resides (also for Medicaid)

• **Eligible Patients**
  - Patient eligibility is not reliant on geographic area or provider shortage
  - Existing relationship requirement waived
Medicaid Considerations

- States can use the following tools to modify their Medicaid programs:
  - 1135 Waivers
  - 1115 Waivers
  - State Plan Amendments (SPAs)
- 49 states and DC have waived the in-state licensure requirement
- 47 states and DC have guidance to expand telehealth coverage
- 38 states and DC have payment parity
- 20 states have waived or lowered telehealth co-pays
Private Insurance Considerations

- No requirements to cover telehealth
- Some plans have stated that they will expand coverage during the public health emergency
Resources
The Role of Telehealth in Tobacco Cessation

September 13, 2018

Resources

Lung Association Resources (www.Lung.org/CessationTA)
Resources

Tracking the Evolving Landscape

• Kaiser Family Foundation - Medicaid Emergency Authority Tracker

• Center for Connected Health Policy - COVID-19 Telehealth Coverage Policies

• Centers for Medicare and Medicaid Services– State Medicaid & CHIP Toolkit
Contact Information

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TELEMEDICINE FOR TOBACCO DEPENDENCE

Evidence and Examples
Kimber Richter PhD MPH, NCTTP
Learning Objectives

• Rationale and Evidence for Telemedicine
• Example of Telemedicine - Connect2Quit
• Importance of Resilience and Advocacy
Why Video Counseling?

• It’s becoming reimbursable
• It could improve counseling quality
  • Increase therapeutic alliance – bond between counselor and client
  • Enhance counseling accuracy and quality by allowing counselor to see non-verbal cues
  • Easier for counselor to remember details about smoker
  • Increase adherence, impact

• Could attract more smokers into treatment
  • Quitlines are underutilized
  • Novelty factor
What Are The Barriers?

• Smokers tend to have lower incomes
  • Less access to computers or smart phones

• Although many have a computer/smartphone, they aren’t always working/connected

• Although many areas have “access” to high-speed internet
  • In reality, bandwidth/data can be very limited in rural/remote areas
  • In urban areas, cost of data can limit access
Evidence for Video Counseling

- Cochrane review of real time video counseling for smoking cessation
  - 2 studies met criteria for review – used either a) computer in Dr. office or b) video via phone
  - Self-reported quit rates for video counseling: 20%, 48%
  - Biochemically verified quit rates: 10%, 38%
  - Telemedicine was as but not more effective as telephone counseling at 6 months-1 year

- Australian study with 655 smokers in rural/remote areas
  - Randomized to 3 groups: video, telephone, written materials
  - Let video participants choose what video platform they wanted to use (FaceTime/Skype)
  - At 4 months, video counselling as effective as telephone and better than booklets alone

Tzelepis et al. Real-time video counselling for smoking cessation. Cochrane Database Syst Rev. 2019
Telephone, The Original Telemedicine

- Telephone Counseling for Smokers in Mental Health Clinics
- 6 VA clinics in Northeast U.S.
- All 577 patients got self-help manual and assistance with medication
- All were randomized to:
  - Specialized multisession telephone protocol
  - Transfer to state quitline
- At 6-months, 26% of specialized counseling quit (18% in quitline)
- Patients getting specialized counseling were more satisfied

Example of Telemedicine

Video Counseling For Treating Tobacco Dependence in Rural Kansas Physician Offices

How Did C2Q work?

- Patients recruited in rural physician offices
- Randomized to get either phone or video counseling
- Phone counseling delivered at home
- Video delivered in *physician offices*
  - Computer/webcam typically installed in an examining room
- 4 counseling sessions (Week 0, 2, 4, 8)
- Strong focus on pharmacotherapy assistance
- Conducted in Spanish and English

Richter et al. 2015.
How We Tested CONNECT2QUIT

RECRUITMENT

Recruit participants from 20 rural clinics

- Staff screen, consent, enroll by phone
- Conduct:
  - Baseline assessment
  - Pharmacotherapy guidance

RANDOMIZATION

TREATMENT

4 Sessions PHONE

4 sessions TELEMEDICINE

FOLLOW-UP

Month 3 assessment / Self-report quits

Month 6 assessment / Self-report quits

Month 12 assessment / Verified quits
# Pharmacotherapy Assistance

<table>
<thead>
<tr>
<th>Medication</th>
<th>Is med safe for you?</th>
<th>Does your insurance cover it?</th>
<th>What people like/dislike about med:</th>
<th>Dosage/Prescription?</th>
<th>Use</th>
<th>Side Effects</th>
<th>Average Cost</th>
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<tbody>
<tr>
<td>Varenicline</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: pill form, Kansas Medicaid covers, reduces cravings and withdrawal Dislikes: takes a week to be fully effective, remembering to take 2x per day</td>
<td>*1-2 pills daily Prescription required</td>
<td>3-6 months</td>
<td>* Nausea * Insomnia * Strange dreams * Headache</td>
<td>Approximately $115 per month ($3.70 per day)</td>
</tr>
<tr>
<td>Bupropion SR 150</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: pill form, Kansas Medicaid covers, may delay or reduce weight gain, reduces cravings and withdrawal Dislikes: takes a week to be fully effective, remembering to take 2x per day</td>
<td>* 1-2 pills daily Prescription required</td>
<td>2 to 6 months</td>
<td>* Insomnia * Dry mouth</td>
<td>1 box of 60 tablets, 150 mg: * Z: $185.99 * W: $167.99 * G: $101.99</td>
</tr>
<tr>
<td>Nicotine Patch</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: Easy to use, Kansas Medicaid covers, effective within 1-2 hours, reduces cravings and withdrawal Dislikes: Remembering to put it on, adhesive problems for some</td>
<td>* One patch per day No prescription required, but, Kansas Medicaid will cover with prescription</td>
<td>6-8 weeks</td>
<td>* Skin rash * Insomnia * Strange dreams</td>
<td>21 mg, box of 7: Nicoderm: $29.99 Generic: $21.99 14 mg, box of 7: Nicoderm: $29.99 Generic: $21.99</td>
</tr>
<tr>
<td>Nicotine Gum (2 mg or 4 mg)</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: you control dose, effective within minutes, reduces cravings and withdrawal, keeps mouth busy Dislikes: Remembering to use enough, dental problems make it hard to chew, having to avoid eating/drinking during use</td>
<td>* 1 piece every 1 to 2 hours &quot;Park and Chew&quot; No prescription required</td>
<td>Up to 12 weeks or as needed</td>
<td>* Mouth soreness * Stomach-ache</td>
<td>2 mg box of 50: * N: $29.99 * G: $22.99 4 mg box of 50: * N: $32.99</td>
</tr>
<tr>
<td>Nicotine Lozenge (2 mg or 4 mg)</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: you control dose, effective within minutes, reduces cravings and withdrawal, keeps mouth busy Dislikes: Remembering to use enough, dental problems make it hard to chew, having to avoid eating/drinking during use</td>
<td>* Weeks 1-6: 1 every 1-2 hrs * Wks 7-9: 1 every 2-4 hrs * Wks 10-12: 1 every 4-8 hrs No prescription required</td>
<td>Up to 12 weeks</td>
<td>* Hiccups * Cough * Heartburn</td>
<td>2 mg, 48 tablets: * Commit: $29.99 4 mg, 48 tablets: * Commit: $29.99 Generic: $24.99</td>
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<tr>
<td>Nicotine Nasal Spray</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: you control dose, effective within seconds, reduces cravings and withdrawal, discreet Dislikes: burning in nostrils, aggravates sinus problems, remembering to use enough</td>
<td>* 1 “dose” = 1 squirt per nostril * 1 to 2 doses per hour * 8 to 40 doses per day Prescription required</td>
<td>3-6 months; taper at end</td>
<td>* Nasal irritation</td>
<td>1 box of 40 ml = $190.99</td>
</tr>
<tr>
<td>Nicotine Inhaler</td>
<td>__Yes __No __Caution</td>
<td>__Yes __No __Maybe</td>
<td>Likes: you control dose, effective within minutes, reduces cravings and withdrawal, keeps mouth/hands busy Dislikes: Remembering to use enough, people can tell you are trying to quit</td>
<td>* 6-16 cartridges/day * Inhale 80 times/cartridge Prescription required</td>
<td>Up to 6 months; taper at end</td>
<td>* Mouth/throat irritation</td>
<td>1 box of 168 cartridges = $166.99</td>
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A typical session
A typical session *(on an ideal day…)*

- Counselor makes reminder call to pt and physician office
- Patient checks in, goes straight to telemedicine room
- Counselor dials C2Q computer at appointed office time
- Counselor conducts session
- Counselor faxes follow up materials to front desk for pt to pick up at checkout
- Counselor/pt set follow up appt with receptionist at checkout

Richter et al. 2015.
% Participants Abstinent at Follow Up**

* P=.046, controlling for gender, age, income, education dependence, Medicaid
**Follow up rates: month 3—83%; month 6—86%; month 12—88%

Richter et al. 2015.
Adherence, Satisfaction

• Phone completed more sessions than Video (2.6 vs 2.4)
• Video used more cessation meds than Phone (56% vs 46%)
  • Video was significantly more likely to use varenicline
• Satisfaction with intervention was high in both groups
  • Video significantly more likely to recommend the program to others
• Video - integrating session into medical home contributed to cessation

Richter et al. 2015.
Liebmann et al. Identifying pathways to quitting smoking via telemedicine-delivered care. 2019
"It's been very, very confusing," said Todd J. Maltese, DO, who runs a Long Island neurology and sleep medicine practice with three providers. "There's no standard way of doing this. Every insurance company, they're asking for different codes and modifiers."
Summary

• Real time video counseling is feasible
  • As effective as phone, MORE effective than self-help booklets
• Patients like video counseling better
• Cost of computer/smartphone may limit access for some patients
  • Telephone counseling is as effective – good alternative
• Connecting patients with medications a critical and overlooked step
• NOT YET TESTED: Will video attract more into treatment?
• Reimbursement for telemedicine – either video or phone—may be a struggle for a while
References


Connect2Quit Team:
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Angela Leon-Salas
Irazema Mendoza
Grace Meikenhous
Upstate Medical University
Upstate Cancer Center
TOBACCO TREATMENT TELEMEDICINE ROLL OUT
THERESA HANKIN RRT, NCTTP
Tobacco Treatment in Practice

- Tobacco Treatment Program Overview
  - Employee program includes free NRT and counseling for employees and eligible family members
  - Upstate Cancer Center Program includes free NRT and medication reimbursement for eligible patients. Free counseling for family members. Patients whose insurance does not cover sessions get their bills for services paid under a grant.
  - Community education programs includes Free Smoking and Vaping Cessation Classes.
  - 28 outpatient hospital based clinics. Patients are referred through EPIC
  - Upstate cover 17 counties, large geographical area
Learning as we go

HIPPA compliant Video Platform
Doxy.me
- Updated clinic version
- Business Associate Agreement to cover HIPPA for all
- Cisco WebEx used for meetings and education platforms

CPT codes “business as usual”

99406 or 99407
Per insurance coverage some ask for additional diagnosis codes such as:
- Tobacco abuse counseling 271.60
- History of nicotine dependence 287.891

Documentation
- Tobacco Treatment Telemedicine Audio or Video Note:
  - < or > than 10 mins
  - If audio only note I document patient declined video
  - As always note should reflect time spent
  - When in doubt MORE is better with charting. You may have audits down the line
More time spent
More “clicks” and items to miss
- Chief complaint (nicotine dependence)
- Level of Service with physician
- Charge per usual with physician put in again
- Arriving and completing the visit, notifying front end

Learning curve
- Scheduling appointments
  - VISITTYPE: Must be telemedicine only
  - Again more clicks to make and easier to miss items

Your Billing Team
- Meeting with team sooner than later
- Keep relationship going
- Request list of denied claims as soon as they are red flagged
- Recommend asking your billing team to continue with telemedicine as part of your clinic's practice
Travel History
No documented travel since 04/01/20

Vital Signs
Other Vitals
Menstrual status: Postmenopausal
OB/Gyn status reviewed: 2/26/2020
Tobacco: None
Smoking Status: Light Tobacco Smoker (Quit: 05/08/2019)
Uses: None

Chief Complaint
Nicotine Dependence

Recent Visits with Me
None

Other Visits in Respiratory Therapy
None
HC SMOKING/TOBACCO USE CESSATION CNSL VISIT:INTENSIV, >10MIN
HC PENTAMIDINE AEROSOL INHALATION FOR PNEUMONIA TX/PROPHYLAXIS
HC SMOKING/TOBACCO USE CESSATION CNSL VISIT:INTERMEDIATE, 3-10MIN

My Favorites

My Charges Entered Within the Last 72 Hours (Respiratory Therapy only)

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<th>Service Date</th>
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<td>99407 CPT®</td>
<td>94295407</td>
<td></td>
<td>6/12/2020</td>
<td>Theresa C Hartin, RRT</td>
<td>Michael D Mor, MD</td>
<td></td>
<td></td>
<td>1</td>
<td>Pard</td>
<td></td>
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<tr>
<td>HC SMOKING/TOBACCO USE CESSATION CNSL VISIT:INTERMEDIATE, 3-10MIN</td>
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<td>94295407</td>
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<td>Michael D Mor, MD</td>
<td></td>
<td></td>
<td>1</td>
<td>Pard</td>
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Tobacco Treatment Audio Only Note: Due to COVID-19 tobacco treatment is being done through telemedicine. Sarah stated understanding and accepts telemedicine but declines video. This is an audio only encounter. We spoke for > than 10 mins. Sarah continues with her treatment plan: 14 mg nicotine patch daily and short acting 2 mg nicotine gum or lozenges used interchangeably Q1-2 as needed for high trigger points or breakthrough cravings. Sarah is about to begin her radiation treatments and is under extreme levels of stress. Sarah reported that the short acting NRT was just not keeping her from lighting up at that point. She has reported smoking again about 15 cigarettes in one week time. We talked about how she can deal with stress without going back to her old "ritual of smoking". We reviewed her motivations for quitting, especially how it relates to her second round of cancer treatments and the possibility of increased side effects from radiation if she continues to smoke. Sarah's husband Shane was not on the call. Sarah relayed that he continues with Bupropion 150 mg BID. He tried the 21 mg nicotine patch once and it gave him a rash at the site of the patch removal. I explained that that is not uncommon and that he can try other sites and use calamine lotion. Sarah reported that Shane is smoking much less but unfortunately went back to chewing tobacco. I recommended that he continue to use the nicotine lozenges that he received thru the Cancer Center Tobacco Treatment Hardship Program. Shane does not need any more NRT at this time. We have a follow up appt in two weeks. They were encouraged to call me with questions/concerns before than. I told Sarah that I was proud of her and Shane for not giving up on living a tobacco free lifestyle.

Electronically signed by Theresa C Hankin, RRT 5/8/2020 11:42 AM
Tobacco Treatment Consultation was done via audio telemedicine for the pulmonary clinic for > than 10 mins.

The smoking cessation services that are available were explained to the client as well as the reasons why it is beneficial to stop using tobacco at any time in one’s life.

36 y.o., smokes cigarettes.

Started smoking at 12 yrs of age.

Smokes 20-30 cpd. Her first cigarette of the day is within 5 mins of waking.

Brand of tobacco used: old country from the Onondaga Nation Reservation.

Client has tried but is not presently using an electronic cigarette.

Client is thinking about quitting.

Stage of change is: Pre-contemplation.

Number of previous quit attempts: "a few".

Medications or therapies that the client has used on previous quit attempts: 21 mg nicotine patch, 2 mg nicotine gum, Varenicline and willpower alone.

Above quit attempts were not successful.

Barriers to quitting: living with another smoker who smokes the same brand of cigarettes that she does, being the primary caretaker for her Mom who is a smoker and who Susan stated has a terminal illness, her history of mental health disorders and a heavy level of nicotine addiction.

Tobacco Treatment Specialist recommendations: We reviewed the program that is available to her, the 3 steps that are proven to help a smoker quit and stay quit, her motivation for trying a quit attempt as well as the fears she has, how she can deal with quitting smoking while living with another smoker, and how combination therapy can keep her comfortable while she is quitting. I recommended that she start by using the nicotine inhaler to replace 1-3 cpd while learning how to use it correctly (we reviewed instructions and I also mailed her a tip sheet on how to use the nicotine inhaler most effectively).
When she is ready to quit her treatment plan will be "double patching" with a 21 and 14 mg nicotine patch daily and the nicotine inhaler used Q1-2 as needed for breakthrough cravings and high trigger points. We have a follow up appt next we via audio as Susan does not have video available.

Provider is aware that scripts are needed thru an in basket message.

Client agreed to phone follow up.

Client is aware that I am available here in the cancer center for ongoing support. This includes immediate family members who want to stop using tobacco products.

Educational materials, the NYS smokers quitline phone number, and my contact info was mailed to the client.

RT Therapist Name: Hankin, Theresa C 4/27/2020 2:13 PM
Electronically signed by Theresa C Hankin, RRT 4/27/2020 2:27 PM

**Jote Details**

<table>
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<tr>
<th>Author</th>
<th>Theresa C Hankin, RRT</th>
</tr>
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<tbody>
<tr>
<td>Author Type</td>
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</tr>
<tr>
<td>Last Editor</td>
<td>Theresa C Hankin, RRT</td>
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<td>4/27/2020 2:27 PM</td>
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Teledicine on 4/27/2020
Telehealth in Practice

Positives
- Able to continue sessions with those clients who are unable to travel
- Increases your scope of practice for clients that live far away
- Some clients actually prefer telehealth and are more compliant
- COVID-19 has rushed along the process for setting up telemedicine/telehealth

Negatives
- Unable to confirm tobacco abstinence without CO monitoring
- Loss of “human connection” such as response to facial expressions
- Unable to hand out educational materials
- Time and money spent mailing educational materials to clients
- Nicotine replacement distribution if applicable

More Negatives
- More time spent in EMR
- More “items” to miss while charting and charging
- Disparity populations often do not have smartphones/computers/video capabilities or high speed internet
- Adaptation of your practice
- Clients not picking up calls or showing up for video
- Repeat calls to reach clients
“I am requesting that you to refrain from using tobacco during our audio or video sessions”

Behavioral health population clients more likely to use as symptoms flare
Thank You!
Best of Luck in your practice

Q AND A TO FOLLOW OUR LAST PRESENTER
COVID-19 PHE
Telemedicine Overview

Jonathan Roberts
Business Office Manager
Upstate University Hospital
During the COVID-19 Public Health Emergency (PHE), telemedicine services have been greatly expanded to help keep vulnerable patients at home, reduce exposure, and limit the spread of the virus.

The purpose of this presentation is to give an overview of these services as they relate to hospital billing. Additional documents and guidance are available to provide more detailed explanations regarding compliance, payor specific billing, and reimbursement.
Telemedicine vs Telehealth

As defined by Medicare:

**Telemedicine** refers to a group of services that may be provided to a patient without any physical patient contact. Services may be provided via a telephone (audio) connection, or via some type of online communication such as a patient/provider portal or via email interactions between the patient and practitioner.

**Telehealth** refers to a distinct level of established services that have traditionally been performed via a face-to-face interaction between the patient and practitioner. These traditional face-to-face services are performed via an audio and video connection as a replacement to the in person, face-to-face interaction.
The terms **Telemedicine and Telehealth** can be used interchangeably depending on the payor or source. It’s important to understand what type of service is being performed and by what means it’s being provided. These include:

**Audio and Video**- Requires real-time audio/video electronic connection between the patient and provider. Services include standard face-to-face Evaluation and Management (E&M) codes.

**Telephone**- Audio only communication between patient and provider. E&M services can be performed via telephone by a physician or APP. Other check in services can be performed by a wide array of providers.

**E-Visits**- patient-initiated communication between patient and provider using an online patient portal.

**Virtual Check-Ins**- short patient-initiated communications with a healthcare practitioner.
# Medicare Telemedicine Service Summary

<table>
<thead>
<tr>
<th>TYPE OF SERVICE</th>
<th>WHAT IS THE SERVICE?</th>
<th>HCPCS/CPT CODE</th>
<th>Patient Relationship with Provider</th>
</tr>
</thead>
</table>
| MEDICARE TELEHEALTH VISITS | A visit with a provider that uses telecommunication systems between a provider and a patient. | Common telehealth services include:  
• 99201-99215 (Office or other outpatient visits)  
• G0425-G0427 (Telehealth consultations, emergency department or initial inpatient)  
• G0406-G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs)  
For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes | For new* or established patients.  
*To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency |
| VIRTUAL CHECK-IN       | A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient. | • HCPCS code G2012  
• HCPCS code G2010 | For established patients. |
| E-VISITS               | A communication between a patient and their provider through an online patient portal. |  
• 99421  
• 99422  
• 99423  
• G2061  
• G2062  
• G2063 | For established patients. |

Location

**Distant Site** also referred to as Hub Site
- Site the provider is located while the telemedicine services are performed.

**Originating Site** also referred to as a Spoke Site
- Site where the patient is located at the time services are performed.

During the PHE the provider and the patient can be located in their homes.
Billing

Institutional (Facility) Billing- Hospital billing on a UB04 claim type.

Professional Billing- Provider billing on a 1500 claim type.

- Most of the telemedicine reimbursement guidelines are specific to professional reimbursement on a 1500 claim type.

- Medicare had groundbreaking guidance on April 30th that changed reimbursement guidelines for hospitals.
**95 & GT Modifiers** - Indicate a service was performed via interactive audio and video telecommunications. They are standard audio/video telehealth modifiers.

95 Modifier typically means that the cpt code is on the AMA Appendix P CPT list. GT would be for all other covered telemedicine services.

**GQ Modifier** - Excellus BCBS has repurposed this modifier to identify telephone only interactions.

**CS Modifier** - Used to identify COVID-19 related services furnished to Medicare beneficiaries starting March 18, 2020 through the end of the PHE, which eliminates cost sharing associated with COVID-19 testing related services. Other payors may also adopt. (Cigna has)

Telemedicine/Telehealth modifiers are payor specific. Some payors don't require modifiers. Grids have been established to identify these specific situations.
**Place of Service (POS)** codes are two-digit codes placed on health care professional claims to indicate the setting in which a service was provided.

- POS 02 is specific to telehealth
- Some payors want a POS of 02 to identify the services as telehealth. Others want the POS that would normally be used if the patient was physically on site.

**Revenue Codes** are 3-digit codes that are used on hospital claims to indicate the setting in which a service was provided, or what type of item/service a patient received.

- The majority of payors accept the revenue codes that would be used for face-to-face services. ie. 510 for clinic visits, 942 for cpts 99406 & 99407. The modifiers identify the service as telemedicine to them.
- UHC wants revenue code 780 which is specific to Telemedicine.
Audio/Video Telehealth services reimburse the same amount as the face-to-face service.

Phone, E-Visits and Virtual Check-ins have separate payment rates.

Some payors allow for telephone only services to be billed as normal E&M CPTs and will pay the same rate as an audio/video service. Medicare has recently increased audio only reimbursement to be more in line with face-to-face reimbursement.

NYS Medicaid will allow the normal CPTs to be used for hospital telephonic services, but will pay a different rate based on the unique rate code that is used.

- Rate Code 7961 Physicians, APPs, Midwives. (Lane 3)
- Rate Codes 7963-7965 are time based rate codes used for other practitioners such as RNs, LCSWs and PTs & OTs. (Lane 5)
## NYS Medicaid Telephonic Reimbursement

<table>
<thead>
<tr>
<th>Billing Lane</th>
<th>Telephonic Service</th>
<th>Applicable Providers</th>
<th>Fee or Rate</th>
<th>Historical Setting</th>
<th>Rate Code or Procedure</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>Lane 1</td>
<td>Evaluation and Management Services</td>
<td>Physicians, NPs, PAs, Midwives, Dentists, RNs</td>
<td>Fee Schedule</td>
<td>Office</td>
<td>CPT Procedure Codes “99211”, “99441”, “99442”, and “99443” “D9991” - Dentists</td>
<td>New or established patients. Append GQ modifier for 99211only</td>
</tr>
<tr>
<td>Lane 2</td>
<td>Assessment and Patient Management</td>
<td>All other practitioners billing fee schedule (e.g., Psychologist)</td>
<td>Fee Schedule</td>
<td>Office</td>
<td>Any existing Procedure Codes for services appropriate to be delivered by telephone. Append modifier GQ for tracking purposes.</td>
<td>Billable by Medicaid enrolled providers. New or established patients.</td>
</tr>
<tr>
<td>Lane 3</td>
<td>Offsite Evaluation and Management Services (non-FQHC)</td>
<td>Physicians, NPs, PAs, Midwives</td>
<td>Rate</td>
<td>Clinic or Other (e.g., amb surg, day program)</td>
<td>Rate Code “7961” for non-SBHC Rate Code “7962” for SBHC</td>
<td>New or established patients.</td>
</tr>
<tr>
<td>Lane 4</td>
<td>Offsite Evaluation and Management Services (FQHC)</td>
<td>Physicians, NPs, PAs, Midwives</td>
<td>Rate</td>
<td>Clinic</td>
<td>Rate Code “4012” for non-SBHC Rate Code “4015” for SBHC</td>
<td>New or established patients.</td>
</tr>
<tr>
<td>Lane 5</td>
<td>Assessment and Patient Management</td>
<td>Other practitioners (e.g., Social Workers, dieticians, home care aides, RNs, therapists and other home care workers)</td>
<td>Rate</td>
<td>Clinic or other includes FQHCs, Day Programs and Home Care Providers</td>
<td>Non-SBHC: • Rate Code “7963” (for telephone 5 – 10 minutes) • Rate Code “7964” (for telephone 11 – 20 minutes) • Rate Code “7965” (for telephone 21 – 30 minutes) SBHC: • Rate code “7966” (for telephone 5 – 10 minutes) • Rate code “7967” (for telephone 11 – 20 minutes) • Rate code “7968” (for telephone 21 – 30 minutes)</td>
<td>Broadly billable by a wide range of provider types including FQHCs, Day Programs and Home Care (e.g., aide supervision, aid orientation, medication adherence, patient check-ins). However, see LHCSA/CHHA assessments and RN visits which get billed under existing rates in Lane 6. New or established patients. Report NPI of supervising physician as Attending.</td>
</tr>
</tbody>
</table>

[https://www.health.ny.gov/health_care/medicaid/covid19/docs/faqs.pdf](https://www.health.ny.gov/health_care/medicaid/covid19/docs/faqs.pdf)
Most payors offered telemedicine services in very limited situations.

The majority of telemedicine services offered by Medicare were only available to patients located in rural geographical areas. The originating site couldn’t be the patient's home. They had to be in a very specific setting like a hospital or physician’s office.

These services were primarily audio/video services and did not include the phone, e-visit and virtual check-in services that are available during the COVID PHE.

Strict technology and HIPPA standards were enforced. Communication technologies like FaceTime and Skype were not allowed.
General E&M Billing for All Payors

Provider: Physician/NP/PA.
Method of Service: Audio/Video
Professional E&M services (99201-99215) are billed on a CMS-1500 bill type with a 95 modifier to identify them as audio-video. Medicare prefers the POS where services were performed.

Method of Service: Audio Only
Provider: Physician/NP/PA.
E&M services that are performed via audio only, cpts 99441-99443 should be used. No modifier.
Telemedicine for Tobacco Cessation Services

CPT 99406 - Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

CPT 99407 - Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

In general, these codes should continue to be used when telehealth/telemedicine services are performed for all provider types.
Telemedicine for Tobacco Cessation Services

Provider: Hospital employed Respiratory Therapist/Tobacco Treatment Specialist

Medicare
CPT 99406, 99407
When: Audio only and audio/video services are performed.
Bill on a UB-04 claim type with a PO or PN modifier.
Claim should list referring or supervising provider.
Reimbursement: Full reimbursement (same as face-to-face)
NYS Medicaid
Provider: Respiratory Therapist/Tobacco Treatment Specialist

Audio Only
Use CPT 99406, 99407
No modifier
Add Rate Code (Likely billing office specific addition)
• 7963- 5-10 minutes
• 7964- 11-20 minutes
• 7965 21-30 minutes

Audio/Video
Use CPT 99406, 99407
95 modifier
Same reimbursement as face-to-face
Commercial Payors
Provider: Respiratory Therapist/Tobacco Treatment Specialist
Coverage: Payor Specific

Audio Only
Some payors may require cpts 98966-98968. Telephone assessment and management service provided by a qualified non-physician health care professional to an established client, parent or guardian
• 98966: 5-10 minutes
• 98967: 11-20 minutes
• 98968: 21-30 minutes

Audio/Video
 Majority will accept 99406 & 99407 with 95 modifier.
CMS “Second Round of Sweeping Changes” April 30th Update

Under the extraordinary circumstances relocation exception a patient’s home can now be an outpatient provider-based department. By making the patient’s home an extension of the hospital the same outpatient services that would normally be provided face-to-face can now be performed using telemedicine technology. These services are billed as “remote” services not telemedicine/telehealth.

This allows hospitals to bill for services performed by providers like Respiratory Therapists & Tobacco Treatment Specialists that previously were not billable when the patient was located at their homes!

This guidance is back dated to March 1st 2020.
PO Modifier-Excepted Outpatient Department. Paid at 100% of Outpatient Prospective Payment System (OPPS)

PN Modifier- Non-Excepted Outpatient Department. Paid at Physician Fee Schedule (PFS)

In order to use the PO modifier the hospital must register each patient’s address as a provider based department with some other basic information. If the patients' addresses are not registered a PN modifier must be used. Hospitals need to email their CMS Regional Office within 120 days of beginning to furnish and bill for services at the relocated on- or off-campus PBD.

Any Questions?
References and Helpful Links

NYS Medicaid

NYS OMH

Medicare
Comments and Questions?
Thank you for joining us!

Please be sure to complete the brief post-webinar evaluation.

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