History of Telehealth prior to the COVID-19 crisis

Prior to the COVID-19 emergency, there was no provision for reimbursement for telehealth for PT, OT and Speech therapy by CMS or commercial payers.

On March 17, 2020 CMS issued a statement saying PT/OT providers can do e-visits, but are not considered telehealth providers. CMS stated that e-visits for Physical Therapists, Occupational Therapists, and Speech Therapists can be billed with HCPCS codes G2061 – G2063, which are time driven codes with certain limitations (only 1 code can be billed every 7 days).

On March 30, 2020, CMS issued an 'interim final rule' stating that several physical therapy codes are covered under telehealth and can be billed at in-clinic rates, but there was a flip side. CMS states PT / OT are not considered eligible telehealth providers since they are not 'distant site practitioners'.

In the words of the APTA: New CMS rule includes Therapy Codes in Telehealth, stops short of allowing PTs to conduct Telehealth Services.

As of April 2, 2020, CMS has yet to declare that PT and OT are considered telehealth providers, and we expect this announcement to follow very soon, because the legislation allows them to do so.

At In Touch EMR, we anticipate this will be authorized soon, for 2 reasons.

1. Healthcare reasons and patient care. (patients need physical therapy even if it is provided remotely)
2. Financial reasons for providers (the G codes pay very little relative to the 9-series CPT codes).

If and when this is approved, CMS will allow payment at 'in-clinic' rates, POS 11 (regardless of whether the therapist is performing the service from clinic or home) and modifier 95 should be used. More information is available in the interim final rule from CMS.

Until this happens, physical therapists have to work in conjunction with 'distant site practitioners' like physicians or nurse practitioners. As of April 2, 2020, PT/OT telehealth can only be provided under Medicare's "incident to" rules, which means:

- A 'permissible telehealth provider' like a physician, physician assistant or nurse practitioner must be on site (no 15% cut for NPP). In a normal world, the physician would have to be on site, when the PT / OT / speech therapist was treating the Medicare beneficiary. However, we do not live in a normal world. During the public health emergency (PHE) associated with the COVID-19 pandemic, CMS has eased the requirement for on-site supervision. This means that a PT / OT / speech therapist employed in a physician practice could provide telehealth services to a Medicare beneficiary. From a billing standpoint, 2 things would happen. The physician's NPI number would appear in box 24J on the CMS-1500 form as explained below. Also, the reimbursement would be made to the physician owned group NP in box 33 on the CMS-1500 claim form.
- Claims must be filed under the NPI of a physician, physician assistant or nurse practitioner (even if the service is rendered by a physical therapist). In practice, this means that when a claim is billed out on the CMS-1500 form, box 24J for the rendering provider should have the NPI of the physician supervising the PT / OT / Speech therapy. In other words, the PT / OT / Speech therapist is rendering the treatment, but under the supervision of the 'distant site practitioner'. This will be considered a telehealth visit with the PT / OT / speech therapist doing incident-to billing in a practice with a supervising physician (CMS has always allowed this, even before the COVID-19 pandemic).

- The patient must have been treated by physician, physician assistant or nurse practitioner in the group (the patient should not be an outside referral)

New information is being released on a daily basis and our COVID-19 response article, as well as this article will be updated to reflect guidelines as they change. Even though policies are being set from the top down, we expect changes to 'trickle down' gradually, which means that several claims that should have been paid, could get denied.

The overall approach to telehealth should be "here's a way for our clinic to maintain continuity with patients, and generate some revenue in the process" until we get past the COVID-19 crisis.

Requirements for Telehealth services

Due to the public health emergency (PHE) of the COVID-19 crisis, the federal government and Centers for Medicare & Medicaid Services (CMS) have relaxed the HIPAA requirements of virtual visits in order to make telehealth more accessible and feasible for both patients and providers, allowing the use of non-public facing applications like FaceTime, Skype and Zoom platforms.

Adherence to the state-specific practice act, state / county laws and contractual obligations with payers (CMS and commercial payers) is the responsibility of every individual PT, OT and speech therapist. It appears many state practice acts are allowing PT / OT and speech therapists to practice telehealth. However, it's best to confirm with the state since every PT / OT and speech therapist's scope of practice is governed by their state practice act. In addition, some state practice acts (like Texas) may allow PTAs and COTAs to practice telehealth (check with your state), but it's important to ask whether payers will allow PTAs and COTAs to get reimbursed for telehealth services.

Take note of the difference between ‘providing telehealth’ and ‘being allowed to provide telehealth’ and ‘getting reimbursed for providing telehealth’. As of 4-5-20, CMS does not list PT / OT / speech therapists as ‘distant site practitioners’ and therefore PT / OT / speech are not approved telehealth providers. For commercial payers, the guidelines vary between payers and guidelines for several payers are included on the In Touch EMR COVID-19 response resource.

In order to provide telehealth services in a state, the PT / OT or speech therapist must be licensed in that state. However, physical therapists (unlike occupational therapists) have a ‘compact’ between states. This means that if a state is a member of the compact, it’s possible to get permission to treat patients in other states in the compact. For more information, visit the PT Compact website.

While it is imperative to check with individual payers and your state regulatory commission as to their specific guidelines, here is a summary of what you need to be aware of to be successful and compliant with this sudden and widespread focus on telehealth.

Take note of the difference between a Telehealth visit and an E-visit. Reimbursement, codes *and* guidelines are different, so it is important that you understand which you are providing to your patients. Though some HIPAA-related regulations have been relaxed at this time, it is best practice to always use a secure, HIPAA compliant platform with encrypted audio-visual communication.

E-Visits, as per CMS 2020 final rule, are “***non face-to face*** patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office”. An example of this would be a communication through the

patient portal. The patient contacts the provider with a question or concern. The provider responds some time later. This situation is neither face-to-face nor in real-time. An e-visit can consist of more than one communication between patient and therapist and can span a period up to 7 days. However, as per CMS, the provider can bill a maximum of one e-visit (G-code) per 7 days. Based on recent guidelines from CMS, physical therapists can provide e-visit services using the place of service 11 (same as in-office visit) or place of service 12. Here are recent guidelines from the Private Practice Section of the American Physical Therapy Association about digital communication with patients.

To qualify as an e-visit three things are required;

1. The provider must have an established relationship with the patient
2. The patient must initiate the visit
3. The patient must verbally consent to the e-visit.

According to the office of the National Coordinator for Health Information technology, telehealth is "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications"

An e-visit, on the other hand, has a more precise definition with a specific use-case. It is not a sweeping, all-encompassing term like telehealth. It is an online exchange of clinical information between a patient and a provider where the provider evaluates one or more specific conditions that lead to a diagnosis and treatment. Under normal circumstances, the e-visit must be done via a secure, HIPAA-compliant online patient portal.

	TELEHEALTH	
DEFINITION	Broad application, may or may not include clinical decision making	Specific use-case (subset
APPLICABLE PROVIDERS	Intended for physicians & other healthcare providers, not physical therapy (as per CMS on 4-2-20)	Recently applicable to phy
SCENARIO	Broad scope – A visit normally done in the clinic, but now done remotely using audiovisual connections real-time, face-to-face with the patient.	Narrow scope – A patient secure online portal. Neith
TYPE OF PATIENT	New and established patient	Normally, only for establi (as per the CMS interim f
PAYER GUIDELINES	Commercial payers may pay for physical therapy services as 'telehealth' (check with individual payers for payer-specific guidelines)	CMS will only pay for ph
BILLING CODES	Typical PT / OT codes (9-series codes like 97001, 97110, 97112, 97530 but not 97140) are appropriate. Commercial payers may accept these (check with each payer since some payers follow CMS guidelines and may accept HCPS codes)	Use HCPS codes (G code regardless of how many e
PLACE OF SERVICE	Generally bill with place of service 02 (check with individual payers for payer-specific guidelines)	Bill CMS with place of se
MECHANISM OF DELIVERY	Delivered using multiple technologies including video conferencing and live chat.	Delivered primarily using for non-public facing appl Google hangouts and vide like Facebook Live, Twitc

Everything you need to know about a patient initiating a telehealth / e-visit consultation

According to CMS, the provider may educate the patient on the availability of the service, but the patient must be the one to initiate the consultation.

It's acceptable for the clinic to notify the patient via website announcements, emails, phone calls and text messages that e-visits are available if the patient has any questions, or wants to touch base with the therapists about questions regarding the home exercise program, or anything related to the plan of care. Another scenario: If the patient calls to cancel an appointment, let them know that an e-visit is available.

The patient should be provided with a phone number or a mechanism to make a scheduled appointment for an e-visit.

Important considerations for telehealth and e-visits

A telehealth visit has to follow protocols of an in-office visit. In other words, the scheduling, benefit verification, authorization of care, documentation and billing occur just like an in-office visit.

When an e-visit is provided, the physical therapist should document the fact that the patient initiated and consented to the e-visit. If possible, record the patient's consent on video with the patient's prior permission. If this is not possible, get the patient's consent on an audio recording or through an electronic signature through a secure patient portal or a secure electronic document (In Touch EMR supports HIPAA-compliant electronic patient signatures). Documentation should describe services provided, including but not limited to assessment and any clinical decision-making performed by the therapist. At In Touch EMR, it is our opinion that a 'quick note' will suffice during the COVID-19 pandemic, as opposed to detailed documentation during the COVID-19 crisis. After the crisis is behind us, the burden of medically necessity will return.

When CMS initially issued the rule on e-visits, they said it can only be for established patients. However, in the interim final rule, CMS said e-visits can be done for new or established patients. Please note that the plan of care does not need to include e-visits. Also, e-visits do not count as visits toward the progress report (10-visit) requirement. The patient can be located anywhere and there are no restrictions on patient location as far as CMS is concerned. However, every PT is governed by their state practice act and can only perform services in a state if they are licensed in that state. It is important to identify who should provide the service. E-visits should be provided by a licensed therapist, not a PTA or COTA.

Temporary leniency from CMS towards copay, coinsurance and deductible payments during COVID-19

For telehealth, CMS requires that copays, deductible and coinsurance be applied under normal circumstances. However, once again, we don't live in a normal world during the pandemic. HHS is allowing providers to waive coinsurance and deductibles during the COVID-19 pandemic. Clinicians are being encouraged to provide e-visits and telehealth. So much so, that in an OIG policy statement about telehealth services during the 2019 COVID-19 outbreak, the language states "For any free telehealth services furnished during the time period subject to the COVID19 Declaration, OIG will not view the provision of free telehealth services alone to be an inducement or as likely to influence future referrals". CMS expressly allows that copays be waived during the COVID-19 crisis. PT / OT and speech practices have the option of collecting all / some / none of the copays during this time. It is the opinion of In Touch EMR that the best business (and legal) decision at this time is to waive the patient copay whenever possible, in an effort to

ease the burden on the patient. Prior to the COVID-19 crisis, the collection of copay was normally a contractual obligation, but we don't live in normal times. Many commercial payers are waiving copays for COVID-19 treatment and some are waiving copays for all telehealth treatment (check with each payer).

If Medicare is primary, then secondary coverage should be applicable, although the guidelines around billing secondary (non Medicare) and the final determination of payment will be made by individual (secondary) payers.

Supporting documentation must show that the visit was initiated by the patient, the patient consented to the e-visit and must also include a brief description of services rendered, including all clinical decision making during the visit.

Note that as per CMS, PT/OT are only allowed to use G2061, G2062 and G2063 for e-visits. More information about these codes and associated guidelines, please visit the section on "E-Visit Guidelines with Medicare" in the In Touch EMR COVID-19 response article.

The telehealth and PT reimbursement rates and guidelines for commercial payers vary, and are constantly changing. For the most part, the 9-series CPT codes (98970-98972) act as the 'commercial equivalents' of the G codes for Medicare. These codes and associated guidelines for several commercial payers are discussed in the section on "Telehealth / E-Visit Guidelines with Commercial Payers" in the In Touch EMR COVID-19 response article.

Telehealth visits consist of audio/video consultations in real-time. This is where FaceTime, Skype and similar type applications come into play. The defining qualities here are *real-time and audio/video.* The communication between provider and patient

must be two-way, real-time, and interactive throughout the entire visit. A billable telehealth visit must also document originating site, provider location, and reason that the patient cannot come into the provider's office. Prior to COVID-19, physical therapists, occupational therapists and speech therapists were not permitted telehealth visits as it was deemed that the patient had to be seen in person in order to receive the adequate standard of care.

As of March 30, 2020, CMS added speech, physical and occupational therapy treatment codes to the list of services that can be provided by telehealth providers. Note that this is temporary during the COVID-19 pandemic. The following codes are now included in telehealth services and per CMS should be paid the same rate as an in-person office visit:

- Physical Therapy Evaluation and Re-evaluation plans: 97161 -97164
- Occupational Therapy Evaluation and Re-evaluation plans: 97165 – 97168
- Speech Therapy Evaluation and Therapy: 92521 – 92524 and 92507

Waiver of originating site requirements and patient pre-existing relationships during the COVID-19 crisis

Another important change due to the current state of emergency is that the originating site requirements have been waived during this time. Telehealth is now allowed for telehealth providers, regardless of where the provider is located (as long as the provider is licensed to practice in that state). It is no longer required that the originating site (patient location) must be an approved practitioner's office, hospital, or clinic located in a medically understaffed rural area. The patient location can be in their own home, in any geographical location, and still qualify as a telehealth visit. The interaction must still include the audio/visual component to be a billable visit, though now the patient can use their own smartphone.

Telehealth services were also bound by the requirement of a three-year pre-existing relationship between provider and patient. As of March 31, 2020, this requirement has also been waived. Telehealth services can be offered to both new and established patients. Even with these more relaxed guidelines it is the responsibility of the healthcare provider to always comply with state laws regarding licensing, scope of practice, patient consent and standard of care. As far as CMS is concerned, the healthcare provider must also qualify as a 'distant site practitioner' in order to practice telehealth.

Phone calls – the alternative to 'traditional' audio-visual telehealth

If the patient does not have access to the technology required for real-time, audio/visual visits, which is a requirement of telehealth services, the provider can now bill for a **telephone call** if authorized by the payer. In the past, phone calls between patient and provider were not considered billable in most circumstances, but during the COVID-19 crisis, some payers will reimburse providers for telephone communication; always check with your individual payers. The following codes can be used for the Qualified Nonphysician Health Care Professional, which now is inclusive of physical, occupational and speech therapists. The phone call must be initiated by the patient and not related to a follow-up for a visit that occurred within the last 7 days:

- 98966 5-10 minutes
- 98967 11-20 minutes
- 98968 21-30 minutes

Documentation guidelines for telehealth visits

Your documentation will be similar to an in-office visit as much as possible.

All PT / OT and speech therapists are governed by their state practice act and other local laws established by state authorities. They are also contractually obligated to the

guidelines established by CMS and commercial payers. Neither the state professional board, other state authorities or payers distinguish between documentation requirements for a telehealth visit versus a 'traditional' in-person in-clinic visit. The burden to establish 'medical necessity' remains the same. Based on what we have heard from insurance companies from our benefit verification department, there have been indications that payers may allow 'brief' documentation, but it's best to check with each payer.

In addition to the 'standard' SOAP note expected during an an in-office visit, telehealth providers are expected to document patient consent, a statement certifying that the visit was telehealth as opposed to in-person, location (patient and provider), start/end time of the visit and information about individuals who assisted the patient during the visit (if any).

Consent from the patient is a requirement for telehealth, just as it is for in-person office visits. Normally, CMS requires patient consent to be renewed annually. While some states are waiving fines and audits for missing consent forms during the COVID-19 pandemic, you will still need (at minimum) a verbal consent (ideally recorded on video / audio or via digital signature on a patient consent document) from the patient before starting a telehealth session. The patient should understand they have an option to refuse treatment, and request the option to be seen in the office as soon as an in-office appointment is available.

From a liability protection standpoint, it is important to document this consent. If you have not done so already, update your patient consent form to include consent for

telehealth services. You can find various templates and examples of consent forms for virtual visits on the internet that can be formatted to fit your own practice.

The same level of documentation that is required for in person office visits is required for telehealth visits. Additionally, the documentation should include a statement that the service was provided using telemedicine, the reason you are seeing the patient through telemedicine, the location of both the patient and the provider, and names of all persons participating in the encounter.

It is important to keep in mind that these new guidelines are probably only temporary so that we may deal with the COVID-19 pandemic as quickly and efficiently as possible.

How to make Telehealth simple and easy for patients

Make sure to have good lighting, a professional background and a spacious area for your demonstration, whether it is in the office or at home. Professional backgrounds are available from photo / video stores.

Start the telehealth visit by informing the patient about your location and assuring them there is no one else around you. Ask if there is someone with them. Make the patient feel confident about the privacy in this situation.

Since the patient will be performing exercises, ask the patient to prop up their phone or device on a table so they do not have to physically hold the device. The patient's safety should be a primary concern for the clinician.

Always maintain eye contact with the patient and try to look at the patient while observing, and at the camera when talking to the patient. Use verbal cues and physical cues (hand movements) to guide the patient. Speak loudly, clearly and concisely.

Approach telehealth as an 'amplified communication environment' which means you

need to project a lot of energy to the patient, since you are not face-to-face with the patient and the physical proximity is lacking. Think of yourself as an actor, trying to get the audience's attention. When you project energy at at a level of 9 on a scale of 1 to 10, your audience of one (the patient) on the screen will only perceive energy at a level of 4 out of 10, so you need to be 'bigger than life' in terms of your auditory, visual and kinesthetic cues. Do not underestimate this, otherwise the telehealth visit will be sub-standard. Explain every single aspect of the plan of care to the patient and smile, smile, smile!

Malpractice insurance and HIPAA considerations for telehealth

Contact your malpractice insurance carrier to make sure that you are covered for telehealth services. Historically, PT, OT and ST services have not been included in telehealth, so make sure you talk to your carrier about this and get an addendum to your existing policy if needed. Your malpractice carrier is also a good source of legal information for you to use to set up best practices for your organization.

Involve an experienced healthcare attorney to update your policies and procedures, your patient consent to minimize your liability during a telehealth service. Have a contingency plan in place for unforeseen circumstances during the visit. For example, what happens when:

- The patient refuses to consent to a recording of the visit
- The visit is not private i.e someone else is in the room with the patient and also being recorded?
- The patient cannot be seen or heard properly
- If the internet goes down and the patient suffers an injury without your knowledge?

- If the patient changes their mind about the telehealth visit and decides they don't want to do telehealth anymore and want to come to your office instead?

It is best to know the patient's exact location prior to starting the telehealth visit. In this manner, emergency services can be dispatched if the patient gets injured during the visit.

Also, security is an important consideration during telehealth services. The Department of Human Health Services has temporarily waived HIPAA compliance rules for tele communications during the COVID-19 emergency. This is a temporary reprieve of HIPAA related obligations during a highly unusual period of time. We expect all the HIPAA guidelines to resume in full force at the end of the pandemic.

This applies to all telehealth visits regardless of whether the diagnosis and treatment is related to COVID-19.

Licensing and credentialing considerations for Telehealth based on originating site and distant site

Telehealth opens up new scenarios and questions in terms of licensure requirements and state-specific provider credentialing. To explain, let's go over 2 scenarios.

1. Patient is located in NY and the telehealth provider is in NY. In order for the therapist to provide telehealth services, the provider should be licensed in NY. In order to get reimbursed by the payer for telehealth services, the provider **must also** be credentialed with that specific payer in NY (in addition to complying with NY telehealth related state practice act, NY telehealth law and NY-specific telehealth payer guidelines)
2. Patient is located in NJ and the telehealth provider is in NY. In order for the therapist to provide telehealth services (to an NJ-based patient), the provider should be licensed in NJ. In order to get reimbursed by the payer for telehealth services, the provider **must also** be credentialed with that specific payer in NJ (the originating site) since the patient

is located in NJ. If the provider is licensed in NJ **but not credentialed** with that specific payer in NJ, the provider can provide the telehealth service but will not get reimbursed by the payer. Being a part of the licensure compact allows PTs greater flexibility in providing telehealth to patients across state lines. For more details, visit the PT compact website. When practising telehealth across state lines in this example, the provider will need to comply with the NJ telehealth related state practice act, NJ state telehealth law and NJ-specific telehealth payer guidelines.

Best practices – How to choose a telehealth vendor

Applications that can be used are those non-public facing applications that allow for video chats, including FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype. Applications like Facebook Live, Twitch, TikTok, and similar video communication applications are public facing, and are not allowed to be used in a telehealth visit. Providers are encouraged to use HIPAA-compliant telehealth communication solutions which have been listed in detail on the In Touch EMR COVID-19 response article.

Here are some best practices when choosing a telehealth vendor. The vendor should:

1. Have a secure, HIPAA compliant patient portal
2. Provide real-time, 2-way audio-visual communication that is secure (i.e not public facing) with end-to-end encryption
3. Require a business associate agreement (BAA)
4. Provide ongoing education about state practice acts, local laws and payer regulations pertaining to the practice of telehealth

Providers must inform the patients that these waived non-public facing applications may have risks related to privacy, and providers should enable all available encryption and privacy modes when using such applications.

While the HIPAA requirements surrounding the telehealth visit have been loosened right now, our opinion is this will change once the pandemic has ended.

You will need to have a secure system in place if you are going to continue with telehealth. Do your research and make sure you invest in a system like In Touch EMR, a system that is HIPAA compliant, with a secure patient portal, and adaptable to your practice framework. To see In Touch EMR's current offering, including a trial period, visit the home page. Consult with your staff as to what they require and expect from a system. Keep in mind that technology changes and advances are made very quickly, so you will have to constantly update. Remember to include the funds for upgrades in your budget.

Your internet connection must be reliable and provide smooth, speedy access to your patients, so don't skimp here. There is nothing more frustrating than trying to speak with someone on a video chat when you must endure constant buffering. There are so many options for internet access now you may even be able to employ a backup method, in case your main internet connection goes down.

Consult with legal counsel, state authorities and each of your payers to be aware of the laws and regulations in your own state and those that apply to your particular scope of practice. Check credentialing with each insurance company to make sure all of your providers are eligible to be reimbursed for telehealth visits and also check individual payer's guidelines for billable services, as they often vary among payers.

You will want to have office policies in place that pertain to the telehealth encounter. Include such things as proper procedure for what to do if the patient needs further attention during the visit, the audio or video is lost in the middle of the visit, the internet goes down or any other reason the visit may get cut short. Knowing what steps to take will give you and your staff the confidence to tackle this new opportunity to expand your practice into telemedicine.

The incredible potential of Telehealth and E-visits for PT / OT & Speech in the post-COVID-19 world

Telehealth has been growing in the background before COVID-19 bought it to the forefront of healthcare. At In Touch EMR, we consider telehealth as being 'on par' with in-person care, albeit with a different delivery mechanism. We expect state regulations and practice acts to support this position. However, it is yet to be seen whether CMS and commercial payers will support the reimbursement of, and (as a result) widespread use of telehealth.

Here are some important questions that should be answered in due course:

- Will the state practice act and local authorities (state and county) allow / expand telehealth for PT / OT and speech?
- Will CMS expand the definition of distant site practitioners to include PT / OT and speech just like commercial payers have started to do during the COVID-19 pandemic? Currently, only 'distant site practitioners' are considered approved telehealth providers. This is not currently allowed as of 4-6-20.
- Will CMS allow 'other healthcare professionals' to be approved telehealth providers during the COVID-19 pandemic? This is not currently allowed as of 4-6-20.

- In a post COVID-19 pandemic world, will CMS allow PT / OT and speech to provide telehealth, without being subject to the incident-to physician requirement? This is not currently allowed as of 4-6-20.
- In a post COVID-19 pandemic world, will other payers allow PT / OT and speech to continue to provide telehealth services? Some payers currently allow this, as of 4-6-20. This appears to be unlikely, but we'll have to wait and see.
- Will more CPT codes be allowed, and will the reimbursement for such codes be 'on par' with in-person visit during and after the COVID-19 pandemic? Which codes will be allowed under telehealth, and which codes will absolutely necessitate an in-person visit?

The answers will determine whether this shift towards telehealth is a short-term trend, or a long-term shift towards an audio-visual delivery model.

Regardless, the change has begun (or forced upon us). At In Touch EMR, we foresee a small, but meaningful shift towards telehealth services (when appropriate) in one form or another in this new world order of healthcare.

On a final note, the importance of in-person visits can never be replaced, but telehealth will assume greater significance and will no longer be a 'fringe' mechanism of delivery in the years to come. Telehealth for PT / OT and speech will forever be etched into the conversation as a viable (and appropriate) delivery mechanism. Practices will use telehealth as an additional revenue source to the in-person, in-clinic visit and cash-paying services.

As always, make sure you are in compliance with your state practice act, state and county laws and reimbursement guidelines by CMS and other payers before rendering telehealth services. Rules and regulations keep changing, so make sure you are always current.

In terms of the delivery of healthcare, PT / OT and speech therapists are at a crossroad unlike any other in decades. It is our recommendation that you embrace this change and prepare for it, as we begin to recover from the COVID-19 pandemic. This will allow your

practice to recover and potential flourish during and after COVID-19. The latest trends from payers and relevant updates from the APTA, CMS and commercial payers can be found on the In Touch EMR COVID-19 response article.

When a practitioner adheres to all applicable laws (practice act, local and payer-specific guidelines) and puts the patient's health at the center of the conversation, telehealth will open up immense opportunities for every PT / OT and speech practice.

References and additional resources:

APTA: CMS Moves to Allow Digital Communications by PTs

In Touch EMR: Financial relief plan and e-visit guidance to reduce your burden and help combat COVID-19

CMS: Interim formal rule dated 3-26-20

OIG policy statement about telehealth services during the 2019 COVID-19 outbreak

APTA: New CMS rule includes Therapy Codes in Telehealth, stops short of allowing PTs to conduct Telehealth Services

PPSAPTA: Furnishing and billing e-Visits: Addressing your questions

Healthit.gov: What is telehealth? How is telehealth different from telemedicine?

Evisit: The Ultimate Telemedicine Guide | What Is Telemedicine?

Telligen: Telehealth start-up and resource guide

AAFP: Coronavirus (COVID-19): new telehealth rules and procedure codes for testing

FSMB: Model policy for the appropriate use of telemedicine technologies in the practice of medicine

APTA: Furnishing and Billing E-Visits: Addressing Your Questions

APTA: Physical therapy evaluation reference table

AAFP: A virtual visit algorithm: how to differentiate and code telehealth visits, e-visits, and virtual check-ins

CMS: Medicare telemedicine healthcare provider fact sheet

AAPC: Get to Know Telemedicine Payment Criteria

Outsource strategies international: Meet the New CPT Codes to Report e-Visits in 2020