Workers' Compensation Division
OAR 436-009, Oregon Medical Fee and Payment
Rulemaking advisory committee meeting summary minutes
May 18, 2020, 1 p.m.

Committee members attending:

David Barenberg	SAIF Corporation
Lisa Anne Bickford	Coventry Workers' Comp Services
Larry Bishop	Sedgwick CMS
Kaylee Bond	CorVel Corporation
Suzanne Bowser PT	Providence
Beth Bunt	Evergreen Family Medicine
Joy Chand	Takacs Clinic
Timothy Craven MD	Providence MCO | MAC
Lacy Dewhurst	Evergreen Family Medicine
Danielle Erb MD	Brain Rehabilitation Medicine
Jennifer Flood	Ombudsman for Injured Workers
Jaye Fraser	SAIF Corporation
Greg Gilbert	Concentra
Ryan Glover	Armworks Hand Therapy
Dee Heinz	SAIF Corporation
Isabel Hernandez	Healthesystems
Dan Howe	Kaiser Permanente
Lisa Johnson	Majoris Health Systems Oregon, Inc.
Mara Kennedy	Providence MCO
Ann Klein	Majoris Health Systems Oregon, Inc.
Lauren Kuenzi	AGC
Erin Magaw PT	BenchMark Physical Therapy
Ryan McClelland	SAIF Corporation
Melissa McGarry	Coventry Workers' Comp Services
Tom Moline PT	Providence Rehab Services
Allison Morfitt	SAIF Corporation
Debra Northrup	CorVel Corporation
John Powell	Evergreen Family Medicine
John Powell	John Powell and Associates
Denneile Ritter	American Property Casualty Insurance Association
Dan Schmelling	SAIF Corporation
Elaine Schooler	SAIF Corporation
Abby Smith	Farmers Insurance
Krista Stevens	Portland General Electric Company
Julie Tucker PT	Salem Health
Jenny Walsh	Providence Health Plan
James Washburn	Kaiser Permanente
Ashley Willard	Travelers
Kimberly Wood	Perlo Construction | MLAC

Rulemaking advisory committee meeting, May 18, 2020
OAR 436-009, Oregon Medical Fee and Payment

Agency staff members attending:

Rob Andersen	Workers' Compensation Division
Stan Fields	Workers' Compensation Division
Tasha Fisher	Workers' Compensation Division
Don Gallogly	Information Technology & Research
Daneka Karma	Workers' Compensation Division
Juerg Kunz	Workers' Compensation Division
Fred Bruyns	Workers' Compensation Division

Summary minutes – all comments are paraphrased unless quotation marks are used:

Fred welcomed the committee and explained that this is the division's second all-virtual meeting. Department staff are joining so they can listen to the committee members' advice and answer questions as needed. Fred added that advisory committees are informal, and he asked for advice about fiscal impacts to assist the division with its fiscal impact estimate that it will file along with proposed rules with the Secretary of State. He also asked the members to consider background noises that may be picked up on the call. Fred asked anyone on the line who has not been receiving notices from him to get in touch so he can keep them informed going forward.

Issue # 1 (1821)

Rule: Appendix B (OAR 436-009-0040)

Issue: In response to COVID-19, the payments for phone and online evaluation/assessment and management were raised to mirror payment of in person visits, effective March 8, 2020. Without a permanent rule change, the payments would return to pre-COVID-19 levels on September 21, 2020.

Background:

- There are four sets of codes where the division raised the fee schedule amounts through temporary rulemaking due to the COVID-19 pandemic:
    - CPT® codes 99441 – 99443: Telephone services that are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified healthcare professional who may report evaluation and management services.
    - CPT® codes 99421 – 99423: Online digital evaluation and management services by physicians or other qualified healthcare professionals. Online digital E/M services require a physician's or other qualified healthcare professional's evaluation, assessment, and management of the patient.
    - CPT® codes 98966 – 98968: Telephone services that are non-face-to-face assessment and management services provided by qualified non-physician, e.g., speech-language pathologist, physical or occupational therapist, to a patient using the telephone.
    - CPT® codes 98970 – 98972: Qualified non-physician healthcare professional online digital evaluation and management services that require the healthcare

professional patient evaluation and decision making to generate an assessment and subsequent management of the patient.

- The division increased the rates for telephonic and online digital evaluation/assessment and management services to mirror payment rates for an equivalent office visit. This allowed providers to increase their capacity to serve patients via telephone or online digital delivery methods. In light of the pre-COVID-19 pandemic discussion around access to care, it may be prudent to continue to make alternatives to in-person visits more widely available. The division seeks advice about the appropriate level of payment for these services going forward.

Options:

- Adopt the fee schedule amounts (in effect since March 8, 2020) for the codes listed in the table below.

Code	Time (Min)	Non-Facility	Facility
99421	5-10	$93.63	$53.40
99422	11-20	$154.35	$106.07
99423	21-30	$223.84	$163.12
99441	5-10	$93.63	$53.40
99442	11-20	$154.35	$106.07
99443	21-30	$223.84	$163.12
98966	5-10	$79.59	$45.39
98967	11-20	$131.20	$90.16
98968	21-30	$190.26	$138.65
98970	5-10	$79.59	$45.39
98971	11-20	$131.20	$90.16
98972	21-30	$190.26	$138.65

- Adopt new payment amounts other than those listed in above table.
- Allow the temporary rule to expire, which results in the following maximum payment amounts, effective September 21, 2020:

Code	Time (Min)	Non-Facility	Facility
99421	5-10	$31.45	$27.07
99422	11-20	$62.91	$55.59
99423	21-30	$101.68	$88.51
99441	5-10	$29.26	$27.07
99442	11-20	$57.06	$54.13
99443	21-30	$83.39	$80.47
98966	5-10	$27.16	$25.12
98967	11-20	$52.95	$50.24
98968	21-30	$77.39	$74.68
98970	5-10	80% of billed	80% of billed
98971	11-20	80% of billed	80% of billed
98972	21-30	80% of billed	80% of billed

- Other?

Fiscal Impacts, including cost of compliance for small business:

Summary minutes:

- Lisa Anne Bickford said it is helpful to continue with payment parity from a bill review/administrative standpoint. She thinks we all accept that this will be around for a while. Incentives to increase the use of telemedicine make sense.
- Timothy Craven asked why there is a different fee for a facility and non-facility service.
- Juerg Kunz explained that this is because regular office visits also have the facility/non-facility payment amounts. He added that he agrees it may not be necessary to have a facility fee, but if circumstances were that a provider should be paid at the facility rate, at least the payment amount is the same as for the office visit.
- Dr. Craven replied that many providers are working from home, so he assumes the facility rate would apply.
- Fred Bruyns responded that we haven't provide much direction about that. Telemedicine under the new rule (0012) is paid at the non-facility rate.
- Juerg Kunz confirmed that this is correct, but that is specifically for telemedicine. If the doctor calls from home, one could argue that the doctor should be paid at the facility rate, because there may be less overhead. He is not aware the division has received that question or that there have been any disputes about it.
- Greg Gilbert said you could look at this another way. The provider might be at home only because they are not going into the office, but eventually will be in the office. Their (Concentra's) clinicians are in the office. Because the division adopted the non-facility rate for telemedicine unless there is an originating site fee, maybe it should do the same here, even though an originating site wouldn't be used for a telephone call. Just keep it consistent; let's do it all non-facility. That's what we have seen in some states, though CMS did not value these telephone services historically, so there has not been much to fall back on. Try to keep this simple. The provider may be at home but is paying rent for the medical office.
- Dr. Craven noted that the non-facility fee is higher than the facility fee.
- Greg Gilbert replied that it is supposed to be. The reasoning is that typically with a non-facility fee you are not seeing that patient in your clinic, where you still have overhead, staffing, etc., but you still have those expenses from a telephone call perspective. He added that he is not sure how it would work for non-facility, and he thinks it applies for a service in a hospital or other facility that is not the provider's clinic.
- Dr. Craven replied that this is confusing.
- Jaye Fraser said we need to keep telemedicine and telehealth separated. She added that, to her telehealth is just a phone call. We had brand new rules on telemedicine that went into effect on April 1, and the department, for good reason, took action so there would be care for workers, even if just a phone call. SAIF is concerned that we are considering this before we have any experience with telemedicine. They haven't processed bills for most of April, so really don't know what the impact is. Jaye recommends we reconvene and have this conversation in mid-July, when we have some experience and can see what is happening with COVID and what happens after we start to reopen. Facilities are starting to open to see patients.

- Allison Morfitt agreed with Jaye about the distinction between telehealth and telemedicine. She noted that the telemedicine rule went into effect April 1, and regarding the telehealth rule, clarifying what can be delivered via a phone call is important to flesh out, and they need some more time to do that.
- Ryan McClelland said he echoed Jaye's remarks. He added that we just had a new telemedicine rule, and then we had another on telehealth. It was necessary, but minimizing change for providers and gathering data about what is and is not working would be prudent at this point. They do not have a lot of data at this time to make informed decisions. Ryan added that his input reflects his discussions with providers and with division staff.
- Danielle Erb said that as a physician she is now completely confused. She has been doing video appointments. Are these telemedicine or telehealth?
- Several committee members replied, "telemedicine."
- Dr. Erb asked if the committee members think all physicians know the difference between telemedicine and telehealth.
- Greg Gilbert replied, "Probably not," but added that, speaking from a physician's practice management perspective, they know the definitions of the codes. One is a phone call. One is audio visual.
- Dr. Erb replied that her notes don't use these terms telemedicine or telehealth, but do refer to video. She added that her comments are relevant to telemedicine, not telehealth.
- Jaye Fraser replied that this is also her confusion, but she finally realized that telehealth is the phone call and telemedicine involves video.
- Greg Gilbert said there is a really good primer with definitions of telemedicine and telehealth published by the International Association of Industrial Accident Boards and Commissions (IAIABC). Greg said he would send this to Fred, who can forward to the committee. Greg added that telehealth is the broader term, and telemedicine is what Dr. Erb as doing, which involves the audio and visual. It can be confusing, but the key thing is to look at the CPT® codes and descriptions. Greg said he is not opposed to waiting to see how things play out, but we probably should not let it expire and have to come back in the winter for more rulemaking when things may potentially get worse.
- Jaye Fraser responded that this rule division is frequently open. She added that it would be better to do something before the rule expires, but SAIF thinks we are doing this a little too quickly. Also, there is a later agenda item about adding a definition of telehealth, and Jaye observed that our discussion of the matter suggests we do need definition.
- Juerg Kunz said that this issue is just about the payment amounts for these codes. He is not sure what we would study in order to reconvene in July.
- Jaye Fraser replied that they want to encourage workers to ***see*** their care providers. Some services are appropriate for telemedicine and telehealth, and for some you really need to go in and see somebody. They agree the fees should be increased, but have concerns that they are as high as they are in the temporary schedule; the rates are doubled.
- Fred asked if the committee members had additional input about the amount of the fee increases.
- Unknown speaker: On page two, the fee schedule is confusing. It should specify telehealth or telemedicine or both. It doesn't say.
- Juerg Kunz replied that these codes are telehealth according to our definition. Our definition of telemedicine is live, real-time audio and video. There are no CPT® codes

that describe that type of telemedicine. Providers use the same codes they would use for the in-person visit but identify it as a telemedicine service by using modifier "95" and the place of service code "02." The codes under issue #1 are described in the CPT® book as telephone or online services. Therefore, there isn't a need to identify these as telehealth codes for the purpose of this discussion.

- Unknown speaker: If I am talking with a case manager on the phone, that would be telehealth?
- Greg Gilbert responded that this would be different, because these codes are for communications with a patient, not for consultations with outside parties.
- Juerg Kunz said Greg is correct.
- Unknown speaker: So long as there is no video it is not telemedicine. It is telehealth.
- Greg Gilbert replied that the service is described by the codes; it is a telephone call or an online communication through your practice management EMR. Greg added that he thinks Medicare wanted to have rates higher during this time. They released these codes to be paid at the beginning of this crisis. Later they increased the reimbursement rates. Historically they did not pay for these. Greg said the questions are, "Is the price right?" Do we want to keep it there or let it go back down to the original price?
- Fred Bruyns said he can provide a little guidance on the time frames. The 180-day span to replace a temporary rule is not a lot of time for rulemaking given the time frames under the administrative procedures act. For instance, if the division filed proposed rules today, the earliest it could hold a hearing would be the middle of June, and then some time after that the division could file permanent rules. If the committee meets again in July – the division will study that; it is open to more than one meeting – and then try to file in July, the rulemaking hearing would be on/around the 15th of August, which is pretty close to when the rules go into effect. So it would tighten the timeframes on the other end, providing less time to get ready – any needed programming or etc.
- Lisa Anne Bickford asked if an extension of the emergency rule is an option.
- Fred Bruyns replied that there is no provision for extending temporary rules. It was the Legislature's way of putting a check on state agencies so they don't do rulemaking with temporary rules and extend them forever. You get one shot. You can replace the temporary rule with a permanent one or let it expire. There may be some alternatives, but extension is not an option. Fred added that the question was a good one.
- Jaye Fraser said she had called Fred and asked him the same question. SAIF is aware that some kind of meeting in July will make things really tight, but again their concern at this point is how much the situation we are in is changing, what the need for continued telehealth/telephone calls with workers – what that is going to look like. They do have concerns about the fees that have doubled or tripled from what they were. There is potential for providers to make more by having a 21 minute telephone call with someone versus actually seeing someone in the office. They don't know how much this will be used and would like to see what happens going into the summer. That will provide them a better sense of what the fees need to be.
- Danielle Erb asked for clarification if the committee is only talking about telehealth right now. She discovered that she has used the wrong codes for the 15 to 20 visits per week she has done since late March. These were telemedicine, and she thought she was doing video appointments. Dr. Erb asked if there would be discussion about telemedicine, because she has done very little telehealth.

- Fred responded that if Dr. Erb has been doing video appointments that she has been doing true telemedicine. He added that he thought insurers would have gotten back to her if something was coded incorrectly.
- Dr. Erb replied that the code she was using was 99423.
- Fred replied that this is a telehealth code.
- Juerg Kunz explained that for telemedicine a provider would bill 99213 or 99214, whatever the level is, and add modifier "95," plus a place of service of "02." That would identify the service as being provided through real time video and audio.
- Dr. Erb said she thinks they will have to rebill every bill they just did.
- Jaye Fraser responded that if the wrong codes were used, they were correcting them. Jaye added that she does not know what other carriers are doing.
- Dr. Erb explained that no one has informed her office that they are using the wrong codes, but everyone is very busy and she would not expect this.
- Jaye replied that they fixed this and Dr. Erb would not have lost any revenue.
- Dr. Erb said that she wouldn't have thought that telemedicine would pay less than telehealth.
- Jaye said that the she doesn't think this is correct, and that is part of their point that when you are seeing a patient, that is different from talking to them on the phone.
- Greg Gilbert said he agrees.
- Dr. Erb said she agrees as well, and the only time they use the phone is when they cannot make the video work. She added that if they schedule a telemedicine appointment and just cannot make it work, that is different from purposely just scheduling a phone call.
- Jaye replied that she concurs with that.
- Dr. Erb said she sometimes calls patients to tell them something but doesn't consider that an appointment. They only consider scheduling a telephone appointment if the patient doesn't have a smart phone. She thinks that if the patient doesn't have the ability to connect, the appointment should be considered the same, but this is rare. She isn't sure the doctor should receive less reimbursement in such cases.
- Juerg reminded the committee that these telehealth codes really are evaluation and management services. These codes would not be used to report a test result or make an appointment.
- Fred Bruyns said he would like the committee to begin discussion of issue number two, but if anyone has to leave early of if they have additional advice after the meeting, they should send to him by email or over the telephone, and he will distribute to others in the division.

The following comments came in near the end of the meeting, but have been placed here for context:

- Ann Klein said they don't have anything new regarding issue #1, but it is early yet for making any permanent rules. There has been an adjustment period to learn about remote services. Ann prefers that we reconvene and look at data. She added that, regarding the reimbursement rate, in determining what it should be and why, we don't have data to tell us why, which would really inform the what.
- James Washburn said he agrees with Ann. They are still trying to study this.

Issue # 2 (1826)

Rule: Appendix B

Issue: Appendix B does not list HCPCS code T1014 (telehealth transmission), even though the code is specifically listed in OAR 436-009-0012 as not payable.

Background:

- A stakeholder noted that under OAR 436-009-0012 - Telemedicine, it states that insurers are not required to pay a telehealth transmission fee (HCPCS code T1014). This code is not found in Appendix B. It would helpful, if the code was listed in Appendix B with a $0.00 fee.
- OAR 436-009-0040(1)(a) states that services billed with HCPCS codes not listed in the fee schedule are payable at 80% of the provider's usual fee. Since HCPCS code T1014 is not listed in Appendix B, it could be interpreted that code T1014 is payable at 80% of billed. Because, OAR 436-009-0012(4)(e) states that insurers are not required to pay a telehealth transmission fee (HCPCS code T1014), adding the code to Appendix B with a payment amount of $0.00 may help clarify that a telehealth transmission is not a payable service.

Options:

- Add code T1014 with a payment amount of $0.00 to Appendix B.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Summary minutes:

- Lisa Anne Bickford: "No concerns"
- James Washburn: "I have no concern."
- Greg Gilbert: "Agree with your option one."
- Jaye Fraser: "We're fine."

Issue # 3 (1825)

Rule: 436-009-0012 Telemedicine

Issue: The division has learned during the COVID-19 pandemic that some stakeholder are uncertain what services may be provided through telemedicine.

Background:

- In 2019, the division held a stakeholder advisory committee meeting discussing the creation of a rule regarding telemedicine. The committee asked the division to create a

rule outlining billing and payment standards for telemedicine services. The committee recommended that the rules should not contain any provisions regarding what specific services are appropriate for telemedicine. Therefore, the committee recommended against referring to specific CPT® codes.

- Although OAR 436-009-0012 does not make any references to specific CPT® codes, because the division has adopted the CPT 2020 in OAR 436-009-0004(2), OAR 436-009 as a whole could be interpreted as restricting telemedicine services to only those listed in Appendix P of CPT 2020.
- Based on the input from stakeholders, the division's intent is not to limit telemedicine to certain codes by rule. However, all services, regardless of the form of communication, must be appropriate, which includes that the form of communication is appropriate for the service provided. Therefore, a clarifying provision in OAR 436-009-0012 may be useful.

Options:

- Add to OAR 436-009-0012(2): Notwithstanding OAR 436-009-0004, medical services that may be provided through telemedicine are not limited to those in Appendix P of CPT 2020. However all services, regardless of the form of communication, must be appropriate. The form of communication must be appropriate for the service provided.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Summary minutes:

- Lisa Anne Bickford said she likes the wording and that it makes more clear what we have previously discussed as a committee, that telemedicine is not restricted to certain codes. This is helpful to let people know it should be restricted. It needs to be appropriate, which makes perfect sense.
- Melissa McGarry said she agrees with Lisa Anne.
- Jaye Fraser said we had a clear conversation during the original advisory committee meeting about not specifying what is and isn't appropriate for telemedicine. Jaye asked if rather than a rule, whether it would be appropriate for the division to issue a bulletin to provide direction. Jaye offered that there is also a question of how much telemedicine is appropriate for certain kinds of treatment. SAIF received a telemedicine bill for acupuncture, and Jaye said she thinks the department would expect them to say that this was not medically appropriate and deny the bill.
- Juerg Kunz said Jaye is correct, and that the underlying principle is that all treatment has to be appropriate. Appropriateness includes the form of communication. Another example would be measuring the passive range of motion; that almost has to be a hands-on service. Juerg added that there has probably been less telemedicine in workers' compensation than in private health and Medicare because of the prevalence of musculoskeletal injuries that require hands-on care. The division just aims to clarify things.

- Jaye Fraser replied that their staff are feeling like they do need some guidelines, but she doesn't know if it needs to be in rule.
- Greg Gilbert said the reason there probably should be some clarification, whether by rule or bulletin, is that payers operate in states that do and do not use appendix "P." In the absence of being clear, the payers will use appendix "P." Greg added that CMS has opened up the scope of telemedicine and he thinks that is probably going to continue.
- Lisa Anne Bickford said she doesn't think it makes a difference whether in rule or bulletin, but guidance is helpful.
- Fred Bruyns said that a bulletin doesn't have the force of law. If someone were to ask the division to enforce appendix "P" in a medical dispute, he isn't sure how that would come out, but they cannot look to the bulletin as a "standard."
- Lisa Anne Bickford said her assumption is that if someone bills for a service outside of appendix "P" that it is permissible even if we change nothing.
- Fred replied that he thinks it is happening.
- Juerg said this is currently our interpretation. If you look at rule 0012, the division didn't mention CPT® codes or lists. But rule 0004 adopts the CPT® book, which includes the "P" codes. This could be interpreted to mean that since the division adopted the CPT® book, telemedicine is limited to the "P" codes. That was never the division's intent. At the last meeting stakeholders asked the division not to list specific codes.
- Lisa Anne Bickford responded that we agreed that it should be up to clinical judgment as to what is appropriate.
- Ryan Glover said Dr. Erb did a great job describing the differences between telehealth and telemedicine. He appreciates being able to use the CPT® codes at their disposal. There is a cost differential of using the regular in-clinic CPT® codes versus the telehealth phone codes, and it appears there is a date range for the telehealth, but there hasn't been anything like this under telemedicine. Ryan added that he thinks we'll be seeing this throughout the year, in the fall and maybe the winter, and asked about the applicability dates.
- Juerg Kunz explained that the telemedicine (audio and video) rule was added effective April 1. That was totally independent of the COVID-19 pandemic. So going forward telemedicine will be allowed. Likewise, there is nothing in the rules that limits telehealth to this COVID pandemic. Before the pandemic, there was very little discussion about phone services and associated fees. One provider group let us know that the telephone evaluation and management codes seem to be undervalued. The first (agenda) issue regarding the level of reimbursement was certainly triggered by the pandemic. Revised payment levels are limited to the 180-day period of the temporary rule, and that is why the committee discussed whether to stay at the new levels, fall back to previous levels, or something in between. Discussion about what is appropriate really has nothing to do with the pandemic. Our fourth issue coming up is not directly related to the pandemic but was triggered by it due to the questions the division has received. Telehealth and telemedicine services will continued to be allowed regardless of the pandemic.
- Ryan Glover responded that this is helpful and that he supports making the clarification described under issue #3.
- Fred Bruyns said that even though the division adopted a telemedicine rule effective April 1 and a temporary rule effective back to March 8, these services have always been

allowed. We have data showing telemedicine services going back a number of years, though not very many services.

Issue # 4 (1822)

Rule: OAR 436-009-0012 Telemedicine

Issues:

- The current rule is limited to telemedicine provisions (real-time interactive audio and video telecommunication), but does not include any provisions regarding other forms of telehealth, such as telephonic or online digital services.
- The current rule is silent regarding billing requirements for telephonic or online digital services.

Background:

- Since the start of the COVID-19 pandemic, providers and patients increasingly have been communicating through a variety of telehealth services. This includes synchronous medical services provided via a real-time interactive audio and video telecommunications system (telemedicine), as well as telephonic or online digital ways.
- While OAR 436-009-0012(2) provides billing instructions for telemedicine services (use of modifier 95 and place of service (POS) "02"), we have learned through questions from stakeholders that it is not clear how to bill for other telehealth services, such as telephonic and online digital services. Additionally, CMS released the following guideline on April 10, 2020: *When billing professional claims for all telehealth services with dates of services on or after March 1, 2020, and for the duration of the public health emergency (PHE), bill with Place of Service (POS) equal to what it would have been had the service been furnished in-person.* The American Medical Association's CPT 2020 lists POS code "02" as telehealth. It may be helpful to stakeholders to add a rule provision that instructs providers to use POS "02" without modifier 95 when providing workers' compensation medical services via telephone or online digital means, regardless of whether the services are provided during or after the period of the PHE.

Options:

- Add a definition of telehealth: Telehealth means the provision of healthcare remotely by means of telecommunications technology, including but not limited to telemedicine and services provided via telephone or online digital means.
- Clarify that the definitions of distant and originating sites apply to telehealth services, not just telemedicine services.
- Clarify that providers should bill for telephonic and online digital services with POS "02" and not use modifier 95.
- Make no change.
- Other?

Fiscal Impacts, including cost of compliance for small business:

Summary minutes:

- Fred Bruyns said that the discussion could begin with the first option on adding a definition of telehealth.

- Greg Gilbert said that because this is so new, and many states follow Medicare guidelines, but Medicare did not have telehealth codes as payable, and they didn't provide much instruction on billing, he is uncertain of the best approach. Telehealth codes stand out because they are very accurately defined and it is pretty clear why they are being used. On the telemedicine side, he might use a 99203, and he has to be able to tell you this service is for telemedicine with place-of-service code "02" and modifier "95." Some states are using the "02" place of service code to distinguish between facility and non-facility services, which is unnecessary if everything is at non-facility, as is true in most, though not all, states.
- Jaye Fraser said she agrees with Greg. Modifier "95" tells SAIF the service is telemedicine, and the codes for telehealth services are self-descriptive. It may be helpful to have a definition explaining that telehealth means a telephonic conversation or something like that.
- Fred asked Jaye if she was in favor of adding a definition of telehealth.
- Jaye said she supported adding a simple definition to reduce confusion, especially for people who are not familiar with the codes.
- Greg Gilbert said the definition they had in the IAIABC white paper was "Telehealth includes a broad range of services such as video conferencing, remote monitoring, online medical evaluations, and transmission of still images, and may involve a nurse, pharmacist, or any other health professional … telemedicine is a subset of telehealth …."
- Jaye Fraser said she doesn't think telehealth has the same meaning in Oregon as the IAIABC's definition.
- Greg Gilbert said he agreed there is probably more to be put in there (the definition).
- Ann Klein said she had the same observation that the definition proposed here does have telemedicine as a subset to it. Yet, throughout the conversation today these services have been put into two separate buckets, not one that is under the umbrella of the other. Ann added she thinks a definition would be helpful, but there needs to be agreement regarding what falls into which bucket.
- Greg Gilbert said he agreed and that there is another term we should be award of: mHealth (mobile health), which is being used in regards to patient portals, education and preventive healthcare. It is a newer term for the use of mobile phones and other wireless technology in medicine. Greg explained that when the original definition of telemedicine came out of CMS, there were whole set-ups where people weren't using their phones or i-Pads or computers, but rather pods – huge machines with video conference capabilities, plus peripherals to measure blood pressure etc. Six or seven years ago telemedicine morphed, and that is why mHealth is out there. Concentra's experience is that people are using their laptops, i-Pads, or their phones for now. He thinks the definition of telemedicine has not kept up with the technology, something for the division to consider in developing one.
- Fred Bruyns said that from some of the discussion, some committee members think that the "02" place-of-service code is not valuable. One can tell from modifier "95" that a given E&M service was a telemedicine service. For the telephone or on-line services, the descriptions of the codes are clear. Fred asked if he misunderstood.
- Greg Gilbert replied that he thinks that is correct. There is precedent in other states that have been using these telephone codes for a while. Place-of-service "02" codes and modifiers are not used with these CPT® codes. Just bill at your normal place of service.

- Jaye Fraser said SAIF is on board with that.

Issue # 5 (1824)

Rule: 436-009-0110 Interpreters

Issue: There are no billing codes or instructions how to bill for interpreter services provided via a real-time interactive audio and video telecommunications system or via telephone. The one hour minimum payment requirement may not be appropriate for services provided via video or telephone.

Background:

- The division has learned that interpreters may provide interpreter services via a real-time interactive audio and video telecommunications system or via telephone. However, the rules do not provide any guidance how to bill for services furnished via real time video or telephone.
- Current rules require insurers to pay interpreters for a minimum of one hour, even if the actual face-to-face time is less than that. The division seeks advice about whether the same one hour minimum should apply, if the service is provided via real time video or telephone.

Options:

- Create Oregon specific codes and fee schedule amounts for interpreter services provided via real time video or telephone.
- Instruct interpreters to use modifiers to be used with existing billing codes (D0004, D0005, and D0006) to identify services provided via real time video or telephone.

- Make no change.

- Other?

Fiscal Impacts, including cost of compliance for small business:

Summary minutes:

- Danielle Erb said that even though things might be opening back up, she does not have space in her exam room for her and the patient and an interpreter all six feet apart. They would have to go to a conference room. She is going to do all recheck appointments remotely unless the patient needs to be seen in the office. Dr. Erb also treats patients with brain injuries, so many of her patients require transportation. That involves a lot of exposure. Having an interpreter on the video calls has been very helpful – cannot do them without the interpreter. Sometimes have a nurse case manager on the call as well. The interpreter provides the same level of service that they would in the office.
- Fred Bruyns asked if any interpreters were on the line, (pause) and said, "Apparently not." Fred said he thought one or two signed up, but probably had appointments; we may

have to reach out to others. Fred then asked if any payers or others have opinions on this issue.

- Jaye Fraser said they are very comfortable having the interpreters participate via telemedicine. They are not sure about the one-hour minimum at this point. She will check with her folks and get us an answer.
- Fred Bruyns asked if, as the payer, do they want to know how the service was provided, because the available codes do not tell them that.
- Juerg Kunz asked Jaye Fraser if she recommends that we create new codes.
- Jaye Fraser said she didn't think new codes are needed, but asked if they can add the "95" modifier.
- Juerg Kunz said that is why it would be nice to have interpreters on this phone call. He doesn't think interpreters can add modifiers to the codes with their software.
- Fred Bruyns said interpreters don't use the standard medical billing form. They would have their own invoices.
- Jaye Fraser said she received a message from her folks. They are okay with the one-hour minimum.
- Abby Smith said they do not have a problem with that and she doesn't think we need additional codes. They can bill as usual. The chart notes from the doctor are going to identify whether there was an interpreter present.
- Jaye Fraser said that was a really good point.
- Lisa Anne Bickford asked if the division would consider doing an FAQ on this topic, regarding terminology, what is and is not appropriate, etc. Especially now with COVID and so many providers jumping into this space that weren't in it before, it might be helpful.
- Jaye Fraser added that she had recommended a bulletin that could serve that function, much like an FAQ.
- Danielle Erb noted we said the telemedicine rule was effective April 1, it was separate from COVID, they can bill for telemedicine, and that this will continue beyond the September date. Will the payment rate for telemedicine remain the same?
- Juerg Kunz confirmed that the payment rate for telemedicine is the same as for in-office visits and will remain the same; it does not have a September deadline.

Fred Bruyns said that if the committee members have additional advice or questions after the meeting they should get in touch with him within the next couple of weeks. If members don't have his email address (fred.h.bruyns@oregon.gov) , call him at 503-947-7717. Fred added that the division will take the committee's advice very seriously, including the recommendation for another meeting; he added that the division does have to keep an eye on September 21. They don't want the rule just to expire and have everything revert to where it was, especially if this particular pandemic is not fully resolved by then or there is some kind of a resurgence. Fred thanked the committee members for their time and acknowledged that participation may have been frustrating at times, not knowing when to join the conversation. However, the committee completed review of the agenda. Fred invited feedback on this meeting and how meetings should be handled in the future.