COVID-19: Telehealth in the Time of Pandemic in PALTC

This meeting will be recorded and will be available at www.fmda.org/journalclub.php

FMDA Journal Club

June 10, 2020

Diane Sanders-Cepeda, DO, CMD – Host
Robert A. Zorowitz, MD, MBA, AGSF, CMD – Presenter

Agenda

- COVID-19 State of the State
- COVID-19 Clinical Updates
- Telehealth in the Time of Pandemic
- Open Discussion

JOHNS HOPKINS UNIVERSITY & MEDICINE | CORONAVIRUS RESOURCE CENTER

Home | Maps & Trends | Testing | Tracing | News & Information | COVID-19 Basics | Videos & Live Events

World Map | U.S. Map | Critical Trends

COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Total Confirmed

1,979,971

Confirmed Cases by Country/Region/Sovereignty

1,979,893 US
739,503 Brazil
493,023 Russia
290,581 United Kingdom
276,583 India
241,966 Spain
235,561 Italy
199,696 Peru
191,523 France
186,522 Germany
177,938 Iran
172,114 Turkey
142,759 Chile
124,301 Mexico

Admin0 | Admin1 | Admin2

Last Updated at (M/D/YYYY)

Cumulative Confirmed Cases | Active Cases | Incidence Rate | Case-Fatality Ratio | Testing Rate | Hospitalization Rate

188

Lancet Inf Dis Article: Here. Mobile Version: Here.
Lead by JHU CSSE. Technical Support: Esri Living Atlas team and JHU APL. Financial Support: JHU and NSF. Click here to donate to the CSSE dashboard team, and other JHU COVID-19 Research Efforts. FAQ. Read more

Global Deaths

112,006

112,006 deaths
US

Global Deaths

US State Level
Deaths, Recovered

30,458 deaths, 67,808 recovered
New York US

12,303 deaths, 28,036 recovered
New Jersey US

7,408 deaths, recovered
Massachusetts US

6,018 deaths, recovered
Illinois US

6,014 deaths, 53,670 recovered
Pennsylvania US

US Deaths, Recovered

Florida's COVID-19 Data and Surveillance Dashboard

Florida Department of Health, Division of Disease Control and Health Protection

Select a County None

Total Cases

67,371

Cumulative Data for Florida Residents:

Positive Residents

65,779

Hospitalizations **11,345**

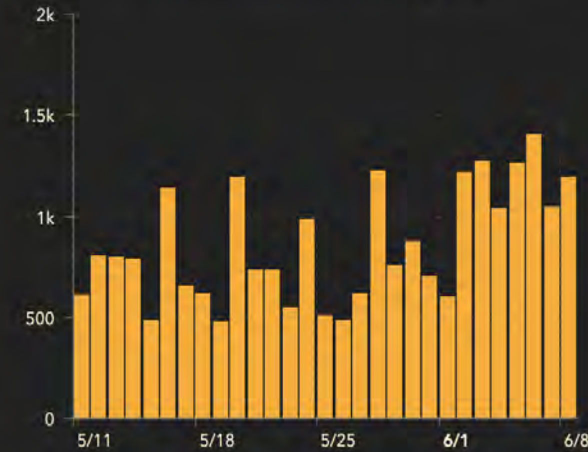
Deaths **2,765**

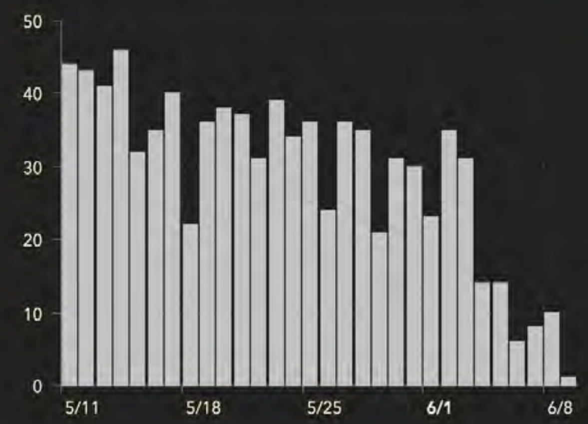
Dothan
Valdosta
Mobile
Pensacola
Tallahassee
FLORIDA
Jacksonville
Gainesville
Palm Coast
Orlando
Lakeland
Tampa
Palm Bay
Port St Lucie
West Palm Beach
Cape Coral
Coral Springs
Miami

FDEP, Esri, HERE, Garmin, FAO, NOAA, USGS, EPA, NPS |...

Data is updated every day at approximately 11 A.M. ET.
Click here to access and download data

Recent Data for Florida Residents (Last 30 Days):





The Deaths by Day chart shows the total number of Florida residents with confirmed COVID-19 that died on each calendar day (12:00 AM - 11:59 PM). Death data often has significant delays in reporting, so data within the past

JUST THE FACTS: WHAT CAUSED COVID-19 OUTBREAK IN NURSING HOMES

LOCATION OF A NURSING HOME WAS THE DETERMINING FACTOR IN OUTBREAKS ACCORDING TO INDEPENDENT ANALYSIS BY LEADING ACADEMIC AND HEALTH CARE EXPERTS; ASYMPTOMATIC SPREAD AND LACK OF TESTING ALSO A KEY FACTOR.

KEY FINDINGS	DAVID GRABOWSKI, PHD *Professor Of Health Care Policy*	VINCENT MOR, PHD *Professor, Health Services And Policy*	R. TAMARA KONETZKA, PHD *Professor Of Health Services Research*
LOCATION OF FACILITY DETERMINED OUTBREAKS	"According to preliminary research presented, larger facilities located in urban areas with large populations, particularly in counties with a higher prevalence of COVID-19 cases, were more likely to have reported cases." [1]	Mor: "If you're in an environment where there are a lot of people in the community who have COVID, the patients in the building are more likely to have COVID." [1]	"Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading." [4]
ASYMPTOMIC SPREAD AND LACK OF TESTING WAS A KEY FACTOR	Grawbowski: "It is spreading via asymptomatic and pre-symptomatic cases…We're not going to get a handle on COVID-19 until we get a systematic testing and surveillance system." [1]	"COVID-19's ability to hide in plain sight will continue to crush expectations of halting its spread unless more and quicker testing at nursing homes sweeps the country, said a top U.S. researcher (Mor)." [3]	"Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected. With policymakers and the public initially focused on the spread of infection within hospital settings, nursing homes often lost that competition." [4]
QUALITY RATING OF FACILITY WAS NOT A FACTOR IN OUTBREAKS	"COVID-19 cases in nursing homes are related to facility location and size and not traditional quality metrics such as star rating and prior infection control citations." [2]	"He (Mor) added that counter to some assertions, regression analyses show that infection rates are unrelated to quality rankings…" [3]	"We found no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death…Indeed, the first death reported was from a nursing home in Washington State that had a 5-star rating." [4]
NO SIGNIFICANT DIFFERENCE BETWEEN FOR- OR NOT-FOR-PROFITS IN OUTBREAKS	"Characteristics that were not associated with a facility having a COVID case included… whether it was for-profit, part of a chain... These factors had no correlation with whether the facility had cases of COVID-19." [1]	N/A	"We found no significant differences in the probability of COVID-19 cases by profit status, with for-profit nursing homes and not-for-profit nursing homes being equally likely to have cases." [4]

[1] *Provider Magazine*, 5/11/20
[2] "Characteristics of U.S. Nursing Homes with COVID - 19 Cases", 6/2/2020

[1] *Provider Magazine*, 5/11/20
[3] *McKnight's Long Term Care News*, 5/11/20

[4] *Testimony to United States Senate Special Committee on Aging, 5/21/20*

Telehealth in the Time of Pandemic (in Post-Acute and Long-Term Care) June 10, 2020

Robert A. Zorowitz, MD, MBA, AGSF, CMD
AGS Advisor, AMA CPT Editorial Panel

Disclosures

- Dr. Zorowitz has no relevant disclosures or conflicts of interest

During this presentation, the participant will:

- Learn how CMS is waiving or relaxing telehealth regulations to accommodate the clinical needs of the COVID-19 pandemic
- Learn how CMS is encouraging the use of telehealth to allow for clinician-patient services that previously required face-to-face encounters
- Differentiate real-time audio-visual telecommunications (RAVT) services from other forms of telecommunication
- Learn how to use CPT and HCPCS G codes to provide telehealth services

The Centers for Medicare & Medicaid Services (CMS) lifted Medicare restrictions on the use of telehealth services during the COVID-19 emergency. Key changes include:

- Retroactive to March 1 and throughout the national public health emergency, Medicare will pay physicians for telehealth services at the same rate as in-person visits for all diagnoses, not just services related to COVID-19.
  - For physician office telehealth services, payment will be made at the non-facility rate
- Patients can receive telehealth services in all areas of the country and in all settings, including at their home.
- CMS will not enforce a requirement that patients have an established relationship with the physician providing telehealth.
- Physicians can reduce or waive cost-sharing for telehealth visits.
- Physicians licensed in one state can provide services to Medicare beneficiaries in another state. State licensure laws still apply.

The main regulatory changes, retroactive to March 1, 2020:

- Telehealth services that were previously restricted to certain zip codes may now be provided and reimbursed regardless of geographic location/zip code and the location of the patient
- Many E&M services that previously required face-to-face encounters may now be provided with telehealth technology and paid at the full rate
- Technology that is not HIPAA compliant may be used
- Frequency limitation for telehealth SNF and Inpatient Hospital visits were eliminated
- Telephone Services may now be provided and reimbursed

Telehealth Modalities

- Must use an interactive real-time audio and video telecommunications (RAVT) system, including, on an emergency basis, commonly used services like FaceTime and Skype that permits real-time communication between the clinician and the patient at home, ALF, hospital or nursing facility.

- HHS Office for Civil Rights OCR will exercise enforcement discretion and waive penalties for HIPAA violations against health care providers that serve patients in good faith

- If the patient is unable to manage the device, a third party—family member, staff member, home health nurse, etc.--may facilitate the telemedicine experience between the patient and clinician by managing the technology onsite

Telehealth Modalities and HIPAA

- Acceptable
  - Apple FaceTime
  - Facebook Messenger Video Chat
  - Google Hangouts Video
  - Whatsapp video chat
  - Skype
  - Dedicated Compliant Telehealth Equipment

- Not Acceptable
  - TikTok
  - Facebook Live
  - Twitch
  - Chat rooms, e.g. Slack

These are examples only and not all-inclusive.

https://www.cms.gov/files/document/covid-final-ifc.pdf

Consent for Telehealth Services

- Should be obtained at least annually
- May be obtained at the time of the service
- May be verbal
- Consent should be documented; may be obtained and documented by auxiliary staff

https://www.cms.gov/files/document/covid-final-ifc.pdf

Types of Virtual Visits and Associated Technology

Communication System	Telehealth E/M	Virtual Check-In[1]	E-Visit[2]	Telephone E/M
Real-Time Audio-Visual (RAVT) Telecommunications System	YES	YES	YES	NO
Other Communication Technology-Based Services (CTBS)[3]	NO	YES	YES	NO
Telephone[4]	YES*	YES	NO	YES

[1]Brief technology-based communication
[2]On-line digital evaluation and management
[3]Includes telephone, audio/video, secure text messaging, email, or use of a patient portal
[4] Audio only

*Retroactive to 3/1/2020

Medicare Telehealth Services

E&M and other services that previously required a face-to-face visit

Eligible Telehealth Services, Effective 3/1/20

- New and Established Office/Outpatient Services (99201-99215)
- Advance Care Planning (99497-99498)
- Initial and Continuing Intensive Care Services (CPT code 99477- 994780)
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels* (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)

*May be submitted only by physician or other qualified healthcare professional, not by PT, OT, SLP

- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224-99226; CPT codes 99234-99236)

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

CPT ® is a registered trademark of the American Medical Association

Eligible Telehealth Services, Effective 3/1/20

- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes99347- 99350)
- Transitional Care Management Services (99495-99496)
- Annual Wellness Visit (PPPS) (G0438-G0439) (Note: the Initial Preventive Physical Exam, IPPE, the so-called "Welcome to Medicare" visit, is not a covered telehealth benefit)

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

CPT ® is a registered trademark of the American Medical Association

Payment for Telehealth Services

- Telehealth services typically provided in person will be reimbursed at the same rate as their typical location
- CMS will not pursue administrative sanctions if a provider reduces or waives co-payments (also applies to remote monitoring services)
- CMS is reimbursing telephone E/M at parity with outpatient/office services

https://www.cms.gov/files/document/covid-final-ifc.pdf

Place of Service (POS) Code – Telehealth

- Prior to these regulatory changes, telehealth services were submitted under POS 02. This will pay at a lower "facility" rate if used.
- Under the interim guidance telehealth services that would have been previously provided in person should be submitted under the same POS as if they were in person (e.g. 11 Office/Outpatient, 12 Home, 31 SNF, 32 NF, etc.)
- Practitioners should submit the E/M code that best describes the nature of the service they are providing
- Use Modifier 95 to identify as telehealth services and receive full non-facility rate.
  - Note that Modifier 95 can be added to services that were not in Appendix P(Synchronous Telemedicine Services) of CPT on 1/1/2020. AMA has added services to match CMS

https://www.cms.gov/files/document/covid-final-ifc.pdf

How to Select E/M Level for Telehealth **Office** E/M visits (p. 136 of IFR*)

- “On an interim basis, we are revising our policy to specify that the **office/outpatient** E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter; and to remove any requirements regarding documentation of history and/or physical exam in the medical record.”
- CMS Total times are not the CPT typical times

*https://www.cms.gov/files/document/covid-final-ifc.pdf

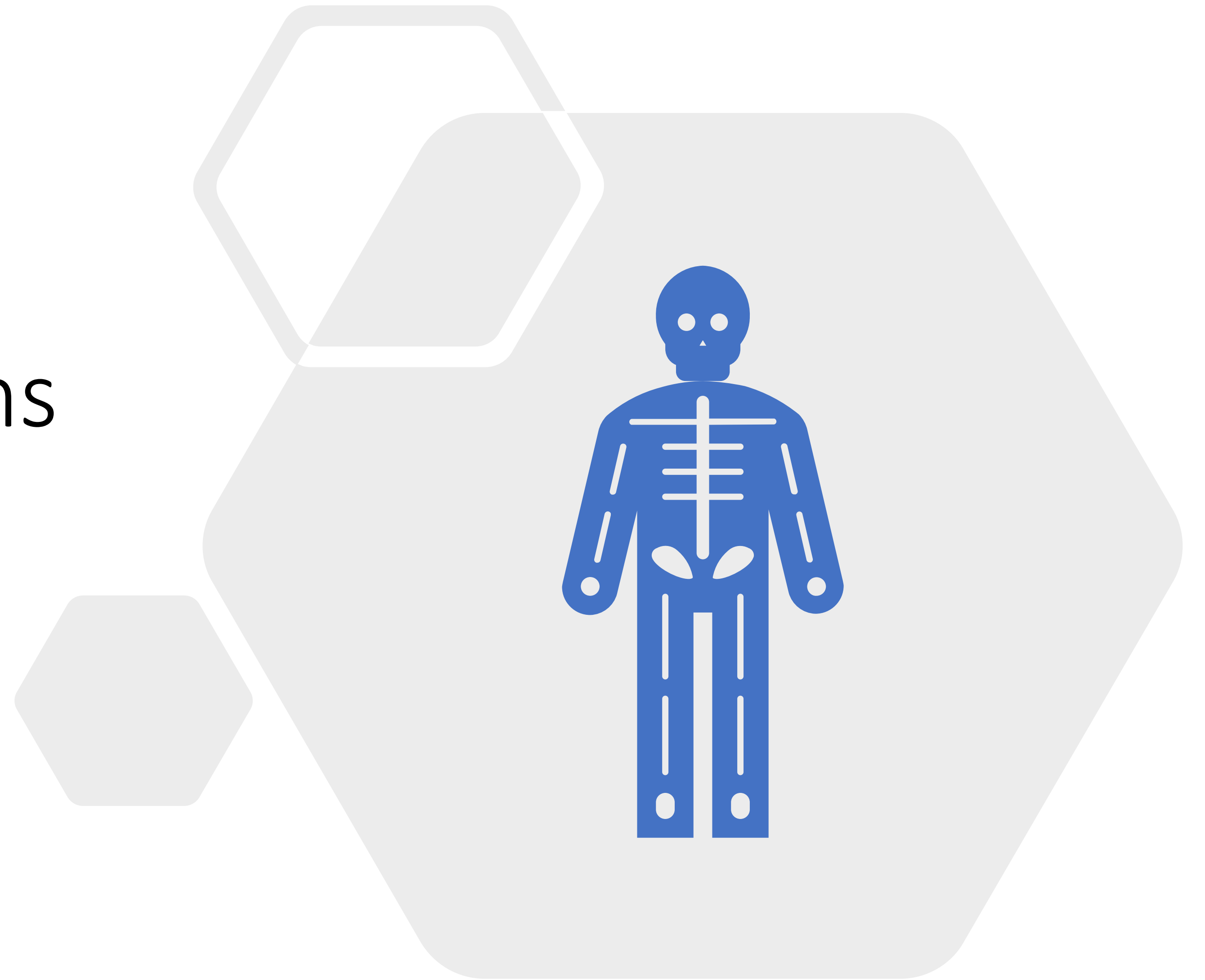
Total Time Office or other Outpatient E/M

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F

CPT ® is a registered trademark of the American Medical Association

CODE	TOTAL TIME (CMS TIME FILES)
99201	17
99202	26
99203	29
99204	45
99205	67
99211	Neither time minimum nor MDM applies
99212	16
99213	23
99214	40
99215	55

What about the nursing home? There are regulations and F-tags!



F-tag 711

§483.30(b) Physician Visits

The physician must—

§483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

§483.30(b)(2) Write, sign, and date progress notes at each visit; and

§483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

Remains the same (but wait…)

F-tag 712

§483.30(c) Frequency of physician visits

§483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.

§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.

§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section.

Remains the same (but wait…)

State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

DEFINITIONS §483.30(c)

Must be seen, *for purposes of the visits required by §483.30(c)(1), means that the physician or NPP must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement. There is no requirement for this type of contact at the time of admission, since the decision to admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.*

Just changed!!!

Medicare Telehealth

- *Physician visits in skilled nursing facilities/nursing facilities:* CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.

https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf

Suggestions for Regulatory Visits

- If resident is stable, consider “doorway” visits
  - Subsequent NF visits require 2/3 components: history, physical and/or Medical Decision Making
- Regulatory visits should be compliant with required frequency
- Visits should be documented accurately and thoroughly
- Notes should be compliant with required content as per CMS
- To perform a telehealth visit, use the resident, family member or a staff member to manage the device

Telehealth Consultations G0406-G0408

- Follow-up inpatient telehealth consultations are furnished to beneficiaries in hospitals or SNFs via telehealth to follow up on an initial consultation, or subsequent consultative visits requested by the attending physician. The initial inpatient consultation may have been provided in-person or via telehealth.
- Follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue.

Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners

https://www.cms.gov/files/document/medicare-claims-processing-manual-chapter-12

Compare Telehealth Services to Telehealth E&M

HCPCS CODE	SHORT DESCRIPTION	NATL FACILITY PRICE
G0406	Inpt/tele follow up 15	$39.70
G0407	Inpt/tele follow up 25	$73.26
G0408	Inpt/tele follow up 35	$105.38
99304	Nursing facility care init	$92.03
99305	Nursing facility care init	$131.73
99306	Nursing facility care init	$169.98
99307	Nursing fac care subseq	$44.75
99308	Nursing fac care subseq	$70.37
99309	Nursing fac care subseq	$92.75
99310	Nursing fac care subseq	$136.78

CPT ® is a registered trademark of the American Medical Association

Compare Telephone Services to Telehealth E&M

HCPCS CODE	SHORT DESCRIPTION	NATL FACILITY PRICE
99441	Tele. E/M, 5-10 mins	$46.19*
99442	Tele. E/M, 11-20 mins	$76.15*
99443	Tele. E/M, 21-30 mins	$110.43*
99304	Nursing facility care init	$92.03
99305	Nursing facility care init	$131.73
99306	Nursing facility care init	$169.98
99307	Nursing fac care subseq	$44.75
99308	Nursing fac care subseq	$70.37
99309	Nursing fac care subseq	$92.75
99310	Nursing fac care subseq	$136.78

*Reimbursed at non-facility rate, if submitted with modifier -95

CPT ® is a registered trademark of the American Medical Association

Compare Telehealth Services to Domiciliary

HCPCS CODE	SHORT DESCRIPTION	NATL FACILITY PRICE
G0406	Inpt/tele follow up 15	$39.70
G0407	Inpt/tele follow up 25	$73.26
G0408	Inpt/tele follow up 35	$105.38
99334	Domicil/r-home visit est pat	$61.35
99335	Domicil/r-home visit est pat	$97.08
99336	Domicil/r-home visit est pat	$137.14
99337	Domicil/r-home visit est pat	$197.77

CPT ® is a registered trademark of the American Medical Association

Compare Telehealth Services to Domiciliary

HCPCS CODE	SHORT DESCRIPTION	NATL FACILITY PRICE
99441	Tele. E/M, 5-10 mins	$46.19*
99442	Tele. E/M, 11-20 mins	$76.15*
99443	Tele. E/M, 21-30 mins	$110.43*
99334	Domicil/r-home visit est pat	$61.35
99335	Domicil/r-home visit est pat	$97.08
99336	Domicil/r-home visit est pat	$137.14
99337	Domicil/r-home visit est pat	$197.77

*Reimbursed at non-facility rate, if submitted with modifier -95

CPT ® is a registered trademark of the American Medical Association

Telephone Services

Telephone Services

99441 Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008, 2013
- *CPT Assistant* Mar 08:6, Apr 13:3, Oct 13:11, Nov 13:3, Oct 14:3, Mar 18:7, Jan 19:13, Mar 19:8

99442 11-20 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008, 2013
- *CPT Assistant* Mar 08:6, Apr 13:3, Oct 13:11, Mar 18:7, Jan 19:13, Mar 19:8

99443 21-30 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008, 2013
- *CPT Assistant* Mar 08:6, Apr 13:3, Oct 13:11, Nov 13:3, Oct 14:3, Mar 18:7, Jan 19:13, Mar 19:8

98966 Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008
- *CPT Assistant* Apr 13:3, Oct 13:11, Nov 13:3, Oct 14:3, Mar 18:7

98967 11-20 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008
- *CPT Assistant* Apr 13:3, Oct 13:11, Mar 18:7

98968 21-30 minutes of medical discussion

- *CPT Changes: An Insider's View* 2008
- *CPT Assistant* Apr 13:3, Oct 13:11, Nov 13:3, Oct 14:3, Mar 18:7

CPT ® is a registered trademark of the American Medical Association

Telephone Services (99441-99443, 98966-98968)

- Used to report episodes of patient care initiated by a patient or guardian of a patient
- If ends with a decision to see the patient within 24 hours or next available urgent visit, do not report the code
- If the telephone call refers to an E/M service performed and reported within the previous seven days, do not report the code
- Cannot be reported if reported by the same provider in the previous seven days for the same problem
- 99411-99413 for those who can report E/M
- 98966-98968 for those who cannot report E/M

CPT ® is a registered trademark of the American Medical Association

Telephone Services

- For the duration of the Public Health Emergency, may be used for both new and established patients (regardless of what is in CPT)
- The nonphysician codes may be used by LCSWs, clinical psychologists, physical therapists, occupational therapists and speech language pathologists
- If used by rehab therapists, require GO, GP, or GN therapy modifier
- Reimbursement at parity with outpatient/office services, retroactive to March 1, 2020

https://www.cms.gov/files/document/covid-final-ifc.pdf

Telephone Services

HCPCS CODE	SHORT DESCRIPTION	NATIONAL CY 2020 NON-FACILITY RATE	NATIONAL CY 2020 FACILITY RATE
99441	Tele. E/M, 5-10 mins	$46.19	$26.35
99442	Tele. E/M, 11-20 mins	$76.15	$52.33
99443	Tele. E/M, 21-30 mins	$110.43	$80.48
98966	Nonphys Tel, 5-10 mins	$14.44	$13.35
98967	Nonphysi Tel, 11-20 mins	$28.15	$26.71
98968	Nonphys Tel, 21-30 mins	$41.14	$39.70
G2012	Virtual Check-In, 5-10 mins	$14.80	$13.35

Note comparison of two 5-10 minute services

CPT ® is a registered trademark of the American Medical Association

Advance Care Planning

CPT ® is a registered trademark of the American Medical Association

Advance Care Planning

HCPCS CODE	SHORT DESCRIPTION	NATIONAL CY 2020 NON-FACILITY RATE	NATIONAL CY 2020 FACILITY RATE
99497	Adv Care Plan, First 30 mins	$86.98	$80.48
99498	Adv Care Plan, addl 30 mins	$76.15	$75.79

- Advance care planning with patient, family and/or surrogate may be performed via telehealth
- Existing CPT descriptor and CMS guidelines still apply

CPT ® is a registered trademark of the American Medical Association

TIPS*

- Think doorway visits, when clinically appropriate (History + MDM)
- Do not forget Non face-to-face Prolonged Services codes 99358-99359
- Make every effort to use real time audio-video technology of any allowed type rather than audio-only or portal-only services.
- Remember that under the PHE, telehealth services may be used for both new and established patients (you will need to obtain consult and insurance info for new patients)
- Document where you are and where the patient is
  - If you are in the same location it is not telehealth, but since telehealth and in-person are the same reimbursement, it may not matter
  - If you are in the same location on an inpatient/NF unit and you use telephone or room intercom to get a history, you are still providing an in-person service <u>in our opinion</u> (remember-subsequent visits require 2/3 components: history, physical, medical decision making)

*Much of this is personal opinion

More TIPS: Use Existing Non-Face-to-Face Services (Partial List)

- Transitional Care Management Services: Face-to-Face visit may be telehealth
  - Moderate Complexity, Face-to-Face Visit Within 14 days, 99495
  - High Complexity, Face-to-Face Visit Within 7 Days, 99496
- Chronic Care Management Services (Clinical Staff Time 99490, Physician/QHCP 99491)
- Complex Chronic Care Management Services (99487-99489)
- Behavioral Health Integration Care Management (99484)
- Prolonged Service Without Direct Patient Contact (99358-99359)

TIPS: On the unit, but room restricted without full PPE and/or room entry only if essential

- You are providing important care and spending time in doing so

- On the unit
  - Go to doorway and assess overall status=routine E/M service (remember-subsequent E/M requires 2/3: history, physical, medical decision making)
  - Do real time audio-video=routine E/M service
  - Do audio only=routine E/M service
  - Do chart only=interprofessional consultation (only use once per 7 days and other restrictions if report E/M) OR if spend 30 minutes total time on a single date associated with past or future E/M use 99358

TIPS: Off the unit, inpatient hospital or SNF/NF care

- You are providing important care and spending time in doing so

- Off the unit
  - Do real-time audio video with patient = code as if on unit and add -95*
  - Talk to patient, audio only= telephone code
  - Talk to patient, family, chart review and documentation spending 30+ minutes on a single day =99358, so long as there is an in-person E/M (or presumably in-person by RTAV) at some point in the future or past.

  - *also may use tele-consult G codes (payment differential inconsistent and de minimis)

Other Payers

- Know your local payers
- Many payers are allowing more expansive services and considering audio-video and audio to be equivalent to in-person. They may also be waiving cost sharing

Payment Policy | Telemedicine Services

EFFECTIVE DATE: 01|01|2018
POLICY LAST UPDATED: 06|20|2017

NEW HAMPSHIRE
Provider Communications

Telehealth Services – professional

Published: Oct 1, 2019 - **Guideline Updates** / Reimbursement Policies

Beginning with dates of service on or after January 1, 2020, claims appended with Modifier 95 and GT (denoting telehealth services rendered) will no longer be reduced by 30%. This change aligns with the Place of Service policy language that indicates place of service code 02 (telehealth) will be eligible for reimbursement under the non-physician fee schedule

Humana update for telehealth visits – effective March 23, 2020

To support providers with caring for their Humana patients while promoting both patient and provider safety, we have updated our existing telehealth policy. At a minimum, we will always follow CMS telehealth or **state-specific requirements**[1] that apply to telehealth coverage for our insurance products. This policy will be reviewed periodically for changes based on the evolving COVID-19 public health emergency and updated CMS or state specific rules[1] based on executive orders. Please refer to the applicable CMS or state specific regulations prior to any claim submissions, and check this page regularly for the latest information.

https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services/covid19-telehealth-services-telehealth.html
https://www.bcbsri.com/sites/default/files/polices/Telemedicine%20Services%20Medical%20Policy%20%20final.docx_.pdf
https://anthempc-attachments-prod.s3.us-west-2.amazonaws.com/pdf/articles/Telehealth%20Services%20%E2%80%93%20professi...%20-%20nh3253.pdf
https://www.humana.com/provider/coronavirus/telemedicine

Other resources for Telehealth Services during pandemic

- Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit

https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf

- Special coding advice during COVID-19 public health emergency

https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf

- AMA quick guide to telemedicine in practice

https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice

- AMA Telehealth Playbook

https://www.ama-assn.org/system/files/2020-04/ama-telehealth-implementation-playbook.pdf

- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19

https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

- Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19

https://www.cms.gov/files/document/covid-long-term-care-facilities.pdf

- Medicare Telemedicine Provider Fact Sheet

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

- Interim Final Rule with Comments

https://www.cms.gov/files/document/covid-final-ifc.pdf

- Telehealth Services (Medicare Learning Network)

https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf

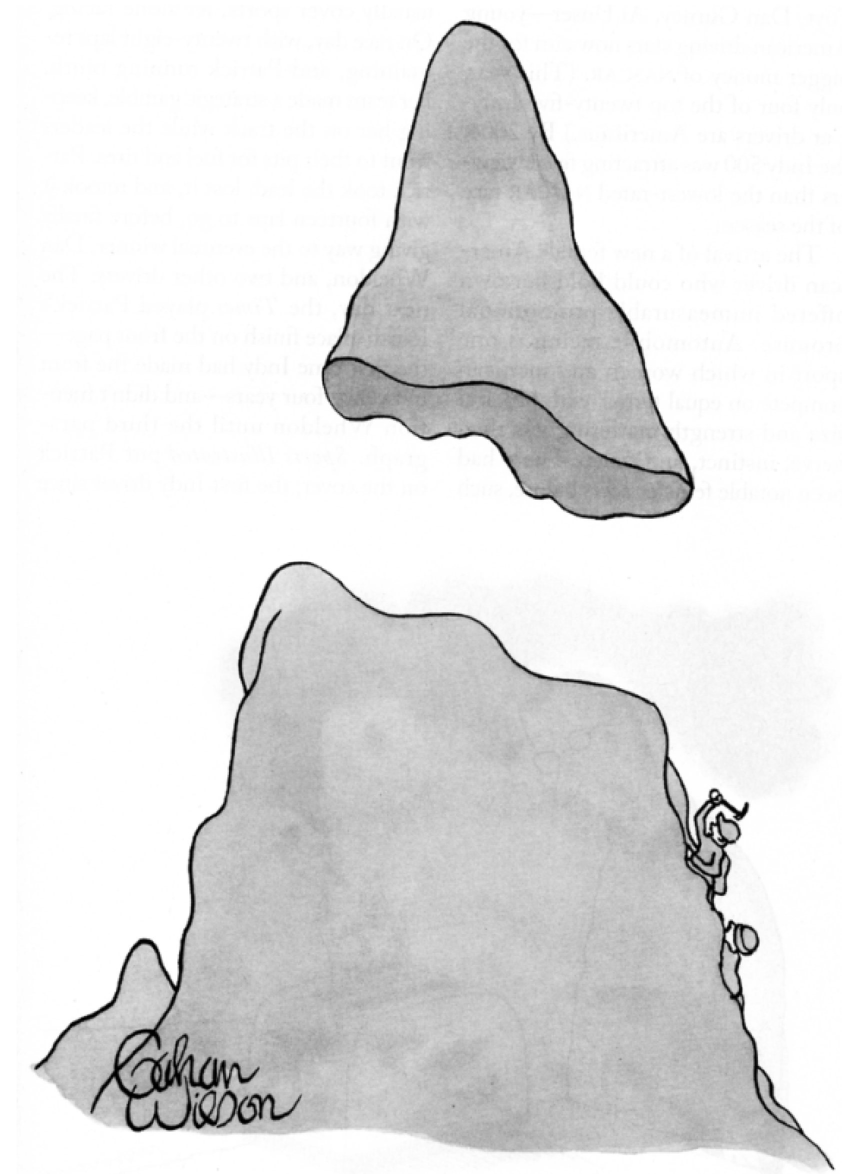
- Federal Register, April 6, 2020

https://www.govinfo.gov/content/pkg/FR-2020-04-06/pdf/2020-06990.pdf

Thank you!

Robert A. Zorowitz, MD, MBA, CMD

bobzorowitz@yahoo.com



“Now here comes the really hard part.”

Open Discussion

The Florida Society For Post-Acute And Long-Term Care Medicine

400 Executive Center Drive, Suite 208
West Palm Beach, FL 33401
www.fmda.org; www.bestcarepractices.org

This meeting has been recorded and will be available at www.fmda.org/journalclub.php