Telehealth Update

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OVERVIEW

- Getting Oriented
- Getting Telehealth Started
- Expanding Telehealth Services
- Sustainability
- Billing/Coding
Resources

Telemedicine Billing:
CMS Loosens Restrictions on RHC & FQHC Telemedicine Services – COVID-19 Updates (BKD)

Medical Practice:
Covid-19: a remote assessment in primary care (BMJ open access journal)
Why the Telemedicine Physical is Better Than You Think (Jud Hollander, MD, Jefferson Health)
Telemedicine: Conducting an Effective Physical Exam (JeffConnect CME course)

Other Resource Lists:
CMS COVID-19 FAQ (35+ pages) AND New Medicare MLN Guidance - April 30, 2020
www.matrc.org/ (click on COVID-19 link)
www.telehealthquickstart.org (Presentations with tips and other resources)
The Realities of Telehealth Billing

1. Telehealth Reimbursement Varies by Payer
   a. Medicare, Medicaid (each state), Commercial (each plan)

2. Telehealth Billing Policies Vary by Payer
   a. There is no “right way” to bill for telehealth
   b. There are many ways, one for each payer
   c. Some payers mimic Medicare; others don’t
   d. CHCs/RHCs almost always have a completely different method (by state)
   e. Every payer is changing/adapting to current situation
1. Historically, Medicare has set a standard for consistent Telehealth billing policies
   a. FFS-based, specific CPT codes, live video only, office/clinic-based, rural limit
   b. CHCs/RHCs could not be paid profees by Medicare for telehealth - originating sites only

2. March 2020 (PHE) Medicare “relaxed restrictions” on telehealth and changed some reimbursement policies to allow wider use
   a. Telehealth is now allowed from any location, and many new codes were added
   b. Use of telephone both allowed and reimbursed at an increased rate
Three Types of “Telehealth” - Name Alert

1. “Telehealth” (per Medicare) - live video encounters that are/were normally billed with various CPT codes (including E/M) with POS 02

2. “eVisits” - Technology-enabled visits, usually using a patient portal or other web-based communication, with images and text (billed 9942x)

3. “Telephone E/M” - A “new” concept using audio-only (telephone) interactions normally billed using 9944x series (medical conversations).

*** Lots of terms being thrown around with various meanings! ***
Technology Enabled Services (FQHC/RHC)

**Telephone**
- "Virtual Check-ins"
- Audio only, providing Rx
- 5+ minutes
- Not related to a service in prior week or next available
- *New or established pts
- *Consent may be obtained at the time of service

**“eVisits”**
- "Online E/M Services"
- Reviewing images and text messages, providing Rx
- 5+ minutes cumulative over 7 days
- *New or established pts
- *Consent may be obtained at the time of service

**“Telehealth”**
- Must be audio/visual; *any video platform
- Any valid TH service
- *80+ new CPT codes
- *From anywhere to anywhere (homes)
- *May waive co-pays


MEDICARE

*New for PHE*
Medicare Reimbursement for “Telehealth”

1. “Telehealth” (per Medicare) - **live video encounters** that are/were normally billed with E/M or BH CPT codes and POS 02

Medicare will reimburse FQHCs and RHCs according to a new process.

- Bill encounters with appropriate CPT codes, **separate from cost report**
  - G0466/67/68/69/70 (FQHC visit type code)
  - CPT/HCPCS Code + Modifier 95 (any valid Medicare telehealth code)
  - G2025 + Modifier 95
- Claims will pay PPS until June 30, then will be re-priced to $92 and **Medicare will claw back any previous payments over $92**

New Medicare MLN Guidance - April 30, 2020 (Link)  
MLN Medicare Fact Sheet 2020
Medicare Reimbursement for “Telehealth”

On **July 1** this will change to:

- Bill ALL telehealth (video) encounters with G2025 + 95, **separate from cost report**
- Claims will pay $92
Medicare Reimbursement for Other Services

2. March 2020 (PHE) Medicare “relaxed restrictions” on telehealth and changed some reimbursement policies to allow wider use
   a. On April 30, CMS revised payment (again) for ALL OTHER remote services
   b. Effective March 1, 2020:
      - Any valid telehealth service from the Medicare list -- G2025 ($92)
      - Telephone-based services (formerly 99441/2/3) -- G2025 ($92)
      - Portal-based services (“eVisits”; 9942x, G2010/12) -- G0071 ($25)
MEDICARE

Technology Enabled Services (FQHC/RHC)

**Telephone - G2025 + 95**
- “Telephone E/M services”
- **Audio only**, providing Rx
- 5+ minutes
- *New or established pts
- *Consent may be obtained at the time of service

**Portal - G0071**
- “Online digital E/M Services” or “eVisits”
- Reviewing images and text messages, providing Rx
- 5+ minutes cumulative over 7 days
- *New or established pts
- *Consent may be obtained at the time of service

**Video - G2025 + 95**
- “Telehealth” (Medicare)
- Must be live video;
  *any video platform
- Any valid TH service
- *80+ CPT codes
- *From anywhere to anywhere (homes)
- *May waive co-pays

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New Medicare MLN Guidance - April 30, 2020 (Link)
For COVID-19 services:

- Waive co-insurance/co-pay
- Add “CS” modifier to any COVID-19 related service claims
Originating Site Facility Fees (Q3014)

Q3014 ($27) is available to an FQHC/RHC when serving as an originating (patient) site only. No qualifying visit is needed.

- Bill on UB-04
- RHC type 711; FQHC type 771
- Revenue Code 780
Medicaid (& Other Payers)

Key concerns:
1. PPS/Encounter rates (vs. FFS)
2. Telephone encounters
3. Allowed patient/provider locations (home)
4. Dental care

Some payers are imitating Medicare, but NOT ALL.

BEST RESOURCES: PCAs and other professional associations, TRCs (SCTRAC)
Cost Reporting Implications

Telehealth visits (CPT-based) are not considered “face-to-face” under Medicare PPS calculations. Direct costs should be segregated and captured in a non-reimbursable cost center, and reasonable allocations of time set aside for nurses and other personnel as well.

Medicaid cost reporting should follow state policy. If your state pays PPS for telehealth, include telehealth costs; if not, keep them separate.
Cross-border **Medical** Practice ([link - FSMB](#))

Cross-border practice is regulated by the foreign states’ licensing boards (and state governments).

The Federation of State Medical Boards (FSMB) maintains a list of all states’ current policies regarding cross-border practice.

For other disciplines (e.g., nursing, psychology, counseling, social work), see each state’s licensing board website.
IMPLICATIONS

Future Considerations
Strategies
Platforms & Configuration
Services
Looking to the Future

Billing and reimbursement will continue to settle unevenly

- Medicare will (attempt to) lead, hampered by political crosscurrents
  - The bulk of CMS’s TH policies were enshrined in statute; in the absence of new telehealth legislation, there was a discernible movement at CMS toward defining new services outside the domain of traditional TH (Virtual Check-Ins, eVisits, CCM/CoCM)

- State payers will vary in speed and pattern of response

- Service models will coalesce around locally reimbursable “sweet spots”
Implications & Strategies

- “Telehealth/Virtual Care strategies” have now become a critical part of your overall strategy
  - **Short term:** Get people seen
  - **Medium term:** Post-COVID overall practice patterns
Considerations for Strategic Planning

- TH regulations and practice will NOT return to the previous state, and the new policies will not be well defined (at least at first)
- Organizations that embrace telehealth will find their patients and providers readily adopt it and experience unforeseen benefits
- Equipment costs will be lower than expected; time/complexity costs will be buried in the general chaos of the coronavirus response
- Care pathways or “channels” will multiply (phone, text, photo, video) along with billing codes (CCM, eVisits, RPM, intra-practice, etc.)
Patient Portals and Other Communication Channels

Push out your Patient Portal. You need it to:

- Set and confirm scheduled appointments
- Send links and passwords for video calls
- Collect patient information before a call
- Conduct an eVisit (as defined by Medicare)

Consider ways to let all your patients know that you’re open and have services available via telehealth.
Website - Leading Patients In

Enhance your website. Let patients know that you’re there and you are responding appropriately.

Help them contact you.
Push Notifications via SMS (Texting)

Many texting companies are offering free introductory deals. Consider them as a way to reach out to patients.

Other “channels”:
- Outdoor banners
- Other usual outreach channels
## Choosing Technology Platforms - The Spectrum

### Standalone Video
- Operates independently of your EMR
- “Dual systems” - video on one screen, EMR on the other (or split windows)
- Configuration and generating “meetings” left up to the user (provider); done via staff process or auto-generated

### “eVisit” Platforms
- Conducted via patient portal or separate eVisit platform
- Supports scheduling, text, images
- Separate from EHR, but may feed it or interact with it
- Support billing “eVisits” (per Medicare definition)

### Fully Integrated EHR
- All scheduling, communication, and texting within EHR
- Expensive & complex
“eVisit” Platforms

Dozens of potential products exist. Lots of confusion and non-standard feature sets. Necessary features include:

- Patient portal (secure 2-way text communication)
- Image uploads
- Symptoms reporting/histories
- Signatures (informed consent)
- Scheduling
- (Optional) Live video calls

Encounters using these platforms are billable as “eVisits” for Medicare
Evaluating Platforms

Comparison Sites:

http://telehealthtechnology.org/toolkit/clinicians-guide-to-video-platforms/ (TTAC)


https://vsee.com/telemedicine-platform-reviews (VSee)

Mozilla Foundation - Video App Security

No “Consumer Reports” comparison exists
CONFIGURE YOUR SOFTWARE

- Enable encryption
- Use passwords
- Disable recording
- Control screen sharing
- Control chat (which is PHI)
- Other optional settings

Assign IT + clinician to audit configuration settings and summarize/report on them
Computers and Peripheral Equipment

**End points**
- Laptop, tablet, or cell phone (with built-in camera, mic, and speaker)
- Desktop (add USB webcam, mic, and speakers)
- Device stand (for cell phones/tablets, esp. patients)

**(Optional Peripherals)**
- Webcam - Logitech C920/922 (or similar)
- Speakerphone - Jabra Speak 410 (or similar)
- Headset - Mpow 071 USB Headset (or similar)
Some General Information and Principles

1. **Services legally occur at the patient’s physical location.** The provider must be licensed (and credentialed) to provide services at that location.

2. Specific consent is generally required, but it may be verbal. It should be included in your general consent, if possible, and regularly revisited.

3. Try to mirror usual procedures as much as possible. Standardized procedures help everyone feel more comfortable. Make telehealth “normal” and professional.

4. In a clinical emergency, use available emergency procedures and resources. Telemedicine services are generally NOT intended for emergencies.

5. **Telehealth services are more demanding physically/mentally/emotionally than in-person care.** Take breaks, slow down, debrief.
Potential Technical Pain Points

Keeping encounters private (separate video products, only).
- Ensuring each client/patient has a secure (unique) link
- “Locking” rooms; using passwords
- Using virtual waiting rooms

Providing technical support to clients/patients who have difficulty.

Alternatives for patients with no cell phones, computers, or connectivity.
POLICIES

Informed Consent
Patient Appropriateness, Location & Safety
Broken Calls
Documentation
Emergencies
Informed Consent

You must document patient consent for telehealth. It can be verbal (for now).
Inform them:

- Calls are not recorded.
- If the call drops, try to reconnect, or call this number ______.
- There are confidentiality risks; how to minimize them.
- Connect from a quiet, private, safe place, with minimal distractions.
- Only use approved software and links provided.
- The patient portal and video are not an emergency contact method.
Patient Appropriateness

Document any concerns regarding the appropriateness of telehealth for this patient or at this time. Concerns may include:

- Difficulty using the equipment effectively
- Lack of access to adequate connectivity or private space
- Inability to collect necessary medical information from patient or perform an adequate exam
- History of or current difficulty managing patient behavior

**NOTE:** Clinical needs and/or urgency may outweigh concerns
Emergency Procedures

As part of the consent/initial session:

- Discuss emergency procedures and any foreseeable risks
- Collect numbers for local fire, police, and other emergency contacts

In an emergency situation:

- Maintain contact and work to transfer care to appropriate onsite responders and/or caregivers
- Document the event and the transfer of care
- Make any mandated reports
PROCEDURES

Scheduling & Room assignment
Opening Script
Presentation & Examination
Disposition & Follow up
Documentation
Use “Front Desk” Staff Effectively

- Allow front desk to schedule encounters and then “pass them off” to providers.
- Develop procedures that enlist front desk and MA staff to virtually “room” and orient patients.
- Develop a “supplemental technical support” pathway or resource for patients.
- Deploy “on site ePPE” as needed
  - Provider in one room, patient in another
  - Patients on WiFi in parking lot
Use An Opening Script

1. Hello [pt]. Can you see and hear me clearly? [Adjust for lighting, sound.]
2. As you know, I’m [Provider]. Can you confirm your name and date of birth for me, please?
3. Can you confirm your location, please?
4. Are you in a private place? Is anyone else in the room or within earshot?
5. Do you have any questions about the privacy of this call or anything else before we begin?
6. If we get disconnected, please reconnect using the same link. If that fails, I will call you at __________. Is that the correct number?
Presentation & Examination

- Use capability provided in the Patient Portal (separate product or through EHR) to collect symptom information and/or complaints
- Use functional questions or other non-contact techniques to assess medical conditions (assume no ability to physically examine the patient)
- Recognize when a physical examination is required for the condition or presentation, and make appropriate arrangements for an exam
- If decisions are made with inadequate information due to urgency, document these decisions and reasons

[Link](http://www.telemedmag.com/article/telemedicine-physical-better-think/)
Disposition & Follow-up

- Record disposition, referrals, and plans as usual in the record
- Refer patients to appropriate staff (video link or phone number) for check-out and follow up
- Follow organizational policies regarding deferral of co-pays
  - Many payers are allowing for waived/reduced co-insurance/co-pays during emergency
  - Of course, that co-pay/co-insurance comes out of your pocket
Documentation

Document encounters as usual for the billing code, including ...

- Patient's location ("Home" is OK, as long as address is on file)
- Provider's location ("Clinic" or "Provider home, via secure clinic portal")
- That the encounter was conducted via telehealth
- Encounter start and stop times
- That the patient consented (unless clearly documented elsewhere)
- Any other people or providers involved, including any presenters

Optional...Provide a reason for using telehealth (medical or otherwise)
PRACTICE

PRACTICE, PRACTICE, PRACTICE

Take some time to gain familiarity and comfort with equipment and software before your first “real” telehealth encounter. Debrief and compare notes if things don’t go as planned, or you need to adjust things.

COMMUNICATE WITH COLLEAGUES AND WORK AS A TEAM
Contact

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