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
Total Cases
67,371

Cumulative Data for Florida Residents:
Positive Residents
65,779

Hospitalizations
11,345
Deaths
2,765

Recent Data for Florida Residents (Last 30 Days):
New Cases of Residents by Day

Resident Deaths by Date of Death

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

<table>
<thead>
<tr>
<th>Key Findings</th>
<th>David Grabowski, PhD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Location of Facility Determined Outbreaks</strong></td>
<td>Professor of Health Care Policy</td>
</tr>
<tr>
<td>“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.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>David Grabowski, PhD</th>
<th>Vincent Mor, PhD</th>
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</thead>
<tbody>
<tr>
<td><strong>Asymptomatic Spread and Lack of Testing Was a Key Factor</strong></td>
<td>Professor, Health Services and Policy</td>
</tr>
<tr>
<td>Grawowski: “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.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vincent Mor, PhD</th>
<th>R. Tamara Konetzka, PhD</th>
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</thead>
<tbody>
<tr>
<td><strong>Quality Rating of Facility Was Not a Factor in Outbreaks</strong></td>
<td>Professor of Health Services Research</td>
</tr>
<tr>
<td>“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.”</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>R. Tamara Konetzka, PhD</th>
<th>N/A</th>
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<td><strong>No Significant Difference Between For-Or Not-For-Profits in Outbreaks</strong></td>
<td></td>
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<tr>
<td>“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.”</td>
<td></td>
</tr>
</tbody>
</table>

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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
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.

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

## Types of Virtual Visits and Associated Technology

<table>
<thead>
<tr>
<th>Communication System</th>
<th>Telehealth E/M</th>
<th>Virtual Check-In(^1)</th>
<th>E-Visit(^2)</th>
<th>Telephone E/M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real-Time Audio-Visual (RAVT) Telecommunications System</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Other Communication Technology-Based Services (CTBS)(^3)</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Telephone(^4)</td>
<td>YES*</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

\(^1\)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

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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 codes 99327-99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341-99345; CPT codes 99347-99350)
- 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

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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

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

• “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

## Total Time Office or other Outpatient E/M

<table>
<thead>
<tr>
<th>CODE</th>
<th>TOTAL TIME (CMS TIME FILES)</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>17</td>
</tr>
<tr>
<td>99202</td>
<td>26</td>
</tr>
<tr>
<td>99203</td>
<td>29</td>
</tr>
<tr>
<td>99204</td>
<td>45</td>
</tr>
<tr>
<td>99205</td>
<td>67</td>
</tr>
<tr>
<td>99211</td>
<td>Neither time minimum nor MDM applies</td>
</tr>
<tr>
<td>99212</td>
<td>16</td>
</tr>
<tr>
<td>99213</td>
<td>23</td>
</tr>
<tr>
<td>99214</td>
<td>40</td>
</tr>
<tr>
<td>99215</td>
<td>55</td>
</tr>
</tbody>
</table>

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

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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...
§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...
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.
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
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.
## Compare Telehealth Services to Telehealth E&M

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>SHORT DESCRIPTION</th>
<th>NATL FACILITY PRICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0406</td>
<td>Inpt/tele follow up 15</td>
<td>$39.70</td>
</tr>
<tr>
<td>G0407</td>
<td>Inpt/tele follow up 25</td>
<td>$73.26</td>
</tr>
<tr>
<td>G0408</td>
<td>Inpt/tele follow up 35</td>
<td>$105.38</td>
</tr>
<tr>
<td>99304</td>
<td>Nursing facility care init</td>
<td>$92.03</td>
</tr>
<tr>
<td>99305</td>
<td>Nursing facility care init</td>
<td>$131.73</td>
</tr>
<tr>
<td>99306</td>
<td>Nursing facility care init</td>
<td>$169.98</td>
</tr>
<tr>
<td>99307</td>
<td>Nursing fac care subseq</td>
<td>$44.75</td>
</tr>
<tr>
<td>99308</td>
<td>Nursing fac care subseq</td>
<td>$70.37</td>
</tr>
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<td>$92.75</td>
</tr>
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<td>99310</td>
<td>Nursing fac care subseq</td>
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<tr>
<td>99441</td>
<td>Tele. E/M, 5-10 mins</td>
<td>$46.19*</td>
</tr>
<tr>
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<td>Tele. E/M, 11-20 mins</td>
<td>$76.15*</td>
</tr>
<tr>
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<td>Tele. E/M, 21-30 mins</td>
<td>$110.43*</td>
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*Reimbursed at non-facility rate, if submitted with modifier -95

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### Compare Telehealth Services to Domiciliary

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<td>G0408</td>
<td>Inpt/tele follow up 35</td>
<td>$105.38</td>
</tr>
<tr>
<td>99334</td>
<td>Domicil/r-home visit est pat</td>
<td>$61.35</td>
</tr>
<tr>
<td>99335</td>
<td>Domicil/r-home visit est pat</td>
<td>$97.08</td>
</tr>
<tr>
<td>99336</td>
<td>Domicil/r-home visit est pat</td>
<td>$137.14</td>
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<tr>
<td>99337</td>
<td>Domicil/r-home visit est pat</td>
<td>$197.77</td>
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## Compare Telehealth Services to Domiciliary

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</tr>
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</table>

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

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Telephone Services

Listen.

Talk.
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


99442  11-20 minutes of medical discussion


99443  21-30 minutes of medical discussion


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

98967  11-20 minutes of medical discussion

CPT Changes: An Insider’s View 2008

98968  21-30 minutes of medical discussion

CPT Changes: An Insider’s View 2008

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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.

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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

## Telephone Services

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>SHORT DESCRIPTION</th>
<th>NATIONAL CY 2020 NON-FACILITY RATE</th>
<th>NATIONAL CY 2020 FACILITY RATE</th>
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</thead>
<tbody>
<tr>
<td>99441</td>
<td>Tele. E/M, 5-10 mins</td>
<td>$46.19</td>
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<td>$52.33</td>
</tr>
<tr>
<td>99443</td>
<td>Tele. E/M, 21-30 mins</td>
<td>$110.43</td>
<td>$80.48</td>
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<td>98966</td>
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<td>98967</td>
<td>Nonphysi Tel, 11-20 mins</td>
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<td>98968</td>
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</tr>
<tr>
<td>G2012</td>
<td>Virtual Check-In, 5-10 mins</td>
<td>$14.80</td>
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</tbody>
</table>

Note comparison of two 5-10 minute services

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Advance Care Planning

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## Advance Care Planning

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<th>NATIONAL CY 2020 NON-FACILITY RATE</th>
<th>NATIONAL CY 2020 FACILITY RATE</th>
</tr>
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<tbody>
<tr>
<td>99497</td>
<td>Adv Care Plan, First 30 mins</td>
<td>$86.98</td>
<td>$80.48</td>
</tr>
<tr>
<td>99498</td>
<td>Adv Care Plan, addl 30 mins</td>
<td>$76.15</td>
<td>$75.79</td>
</tr>
</tbody>
</table>

- 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 in our opinion (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

https://www.humana.com/provider/coronavirus/telemedicine
Other resources for Telehealth Services during pandemic

- Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit
- Special coding advice during COVID-19 public health emergency
- AMA quick guide to telemedicine in practice
- AMA Telehealth Playbook
- Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19
- Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities): CMS Flexibilities to Fight COVID-19
- Medicare Telemedicine Provider Fact Sheet
- Interim Final Rule with Comments
- Telehealth Services (Medicare Learning Network)
- Federal Register, April 6, 2020
Thank you!

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“Now here comes the really hard part.”
Open Discussion
This meeting has been recorded and will be available at www.fmda.org/journalclub.php