

Q & A companion to the ASPN Workforce Committee Telemedicine Webinar March 2020

1) How do you go about documenting the physical examination in a telehealth visit?

Many physical examination findings can be gleaned from inspecting the patient during the telehealth visit. It is reasonable to acknowledge in your documentation that your exam was limited due to the nature of the telehealth communication platform. A sample physical exam courtesy of Jason Misurac, MD is below:

General: No apparent distress. Awake, alert, well appearing. HEENT: Normocephalic/attraumatic. Mucous membranes are moist. No periorbital edema. Facial muscles move symmetrically. Neck: Neck is symmetrical with trachea midline. Eyes: Conjunctiva and eyelids normal bilaterally. Pupils equal and round bilaterally. Respiratory: breathing unlabored, no tachypnea. Cardiovascular: No edema, No pallor, No cyanosis. Abdomen: Non-distended. Skin: No concerning rash or lesions observed on exposed skin. Extremities: Wide range of motion observed. No peripheral edema. Neuro: Mood and behavior appropriate for age. Symmetric and appropriate movements of extremities.

2) Do you need a patient/ guardian consent for a Telehealth visit?

Yes. Prior to Covid-19 public health emergency (PHE), a written/ electronic consent must be obtained prior to initiating Telehealth services. In many institutions, the office support staff or scheduling department would be responsible for obtaining those forms prior to the visit. Some include a link to the consent form in the telehealth visit email invitation and families can complete the form via software such as DocuSign. Since the PHE, the consent method has been relaxed and a verbal consent obtained by the provider with proper documentation that a consent has been obtained in the medical records will satisfy that requirement.

3) How do you bill for a Telehealth visit?

Some institutions utilize a billing and coding service that will handle that on the back end. If you have to drop you own charges, the current guidelines effective during the PHE allow the use of the same codes you would normally use for in-person visits (**99201-99205 for NEW patients**) and (**99211-99215 for ESTABLISHED patients**) with the addition of a **modifier (95)** indicating “*synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system*”, or **modifier (GT)** indicating “*via interactive audio and video telecommunications systems*”. Your **Place of Service** should be **(02)** indicating “*Telehealth*”. See slides 28-29 in slide deck for more information.

4) Is there telehealth care visit payment parity compared to a face-to-face visit?

In the wake of the COVID19 PHE, CMS announced payment parity for telehealth visits for all Medicare claims. CMS also announced that state Medicaid programs who move to pay for telehealth care at parity no longer are required to file a state plan amendment (SPA) to encourage more telehealth visits. Many states are starting to adopt similar parity requirements for private insurers.

5) Is it preferable to bill based on time or complexity for a Telehealth visit?

Since telehealth billing codes mirror in-person visit billing codes, it is important that your documentation is consistent with the billing codes being used. Given the physical exam limitation, it may be difficult to meet complexity target for the higher-level billing codes. In those situations, billing based on time may be more appropriate. If you will bill based on time it is important to document the visit START and END times in your note. Many telehealth software platforms have a timer feature that you can activate to keep track of the visit time.

6) When the telehealth visit involves a minor patient (< 18 years old), does the minor patient have to be physically present at the originating site? What if you reach the parent at work via a telephone or video visit?

Prior to the PHE, payers had certain restrictions on the originating site (where the patient is located to initiate the telehealth visit) which ultimately meant that the child would accompany the parent to the originating site and be present for the encounter. As those regulations have been relaxed, and the patient's home (or caregiver's work location) can become the originating site it is unclear whether the physical presence of the patient can be enforced in those situations. Certainly, if the encounter is limited due to technology to a telephone visit (ie virtual check-in), the immediate presence of the minor patient on the other end at the time of the visit is likely not critical to the conduct of the visit. It is best to document who's participating in the phone or video call at the start of any telehealth visit. It is also worth considering a reminder call from your office support staff to encourage the family to be prepared with the patient at the time of their scheduled visit.

7) Can telehealth be used for inpatient care?

Yes, several inpatient services can now be furnished via telehealth during the Covid-19 PHE. For a full list of covered service and their billing codes please refer to the following link:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

8) Are there any potential liability issues when providing telehealth services?

Telehealth service provision, as with provision of any in-person medical services, is subject to the same rules and regulations governing the delivery of proper medical care consistent with agreed upon ethical and best practice standards. While the HIPAA regulations have been relaxed during the PHE with regards to the technologies that can be used to deliver telehealth services, it is important to always act in good faith and try to maintain patient privacy and confidentiality as much as possible. Acknowledge the limitations of the telehealth medium to the patient at the outset and indicate that it is not a perfect substitute to an in-person evaluation. Encourage the patient to seek in-person care if you deem that to be necessary based on your professional judgment. Always obtain a consent from the patient before providing telehealth services. The consent can be obtained verbally during the Covid-19 PHE.

Please also be aware of any potential state-specific licensing requirements prior to conducting your telehealth visit and confirming the state where the patient is physically located prior to the conduct of the telehealth visit. These laws are changing rapidly. A helpful resource that is updated frequently is from the AAP: <https://downloads.aap.org/DOCCSA/State-Telehealth-Notices.pdf>

9) How do you provide telehealth services for patients that are self-pay? Do you use the same sliding scale as for standard visits?

Payments and visit deductibles for telehealth will be handled differently depending on your local institution. However, the HHS Office of Inspector General is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs to encourage telehealth visits. Many commercial insurers, and states have also followed suit by waiving deductibles.

10) How are you handling hypertensive patient visits without obtaining BP and vitals?

There are several workarounds in this situation. The most ideal is if the family has an automated blood pressure monitor or a family member trained in obtaining manual auscultated BP measurements. You can ask the family to keep a detailed home BP log for several days leading up to the visit and review the log during the virtual visit. You can also ask them to obtain a BP measurement in real time during the visit. Many families may have access to a scale and a thermometer to report a day of visit weight and temperature as well. If they do not have a BP monitor, the next best option would be a quick visit to their local PCP a few days prior to your telehealth visit. The local PCP is a more convenient option for the family and likely is quicker to minimize exposure during the PHE. If that is not an option, you can still conduct your telehealth visit with a focus on reviewing medication regimen, adherence, side effects and providing education on

healthy eating and exercise while acknowledging the limitation of not having updated BP measurements.

11) Can you use telehealth for the monthly PD comprehensive visit? Any use in HD?

Yes, you can conduct the monthly comprehensive PD visit as well as the monthly comprehensive HD visit (along with up to 3 additional weekly check-ins for HD patients) via telehealth using the same MCP (monthly capitated payment) visit codes for in-person visits.

12) Can you do a repeat virtual check-in within 7 days?

A virtual check-in is a brief 5-10 minutes of patient-initiated communications with a healthcare practitioner. It is limited to established patients only. The communication technology modalities include synchronous discussion over a telephone or asynchronous exchange of information through video or image. **It must not be related to medical visit within prior 7 days** and must not lead to medical visit within 24h. However, If the patient initiates another virtual check-in within 7 days **unrelated to the reason of the prior virtual check-in**, there does not appear to be a specific limitation to that scenario. Similar to in-person clinic visits, telehealth visits have no frequency limitations or restrictions.

13) The telehealth guidelines differentiate between new and established patients regarding the need for an exam. How do you conduct an exam for a NEW patient?

The telehealth guidelines during the Covid-19 PHE now allow rendering those services to NEW patients as opposed to services being limited to established patients who have been examined in-person at a prior encounter. As such, a virtual exam for the new patients acknowledging the limitation of the telehealth medium should suffice. See #1 above for a sample PE documentation.

14) Can you bill for phone consults from PCPs?

Yes, as of April 2, 2020 CMS provides coverage for physician phone call consults as follows:
 99441: 5-10 minutes of medical discussion. \$14.44
 99442: 11-20 minutes of medical discussion. \$28.15
 99443: 21-30 minutes of medical discussion. \$41.14
 Place of service (11) for Office.

15) Can you bill for inpatient consults done by telephone or chart review to minimize patient contact when you receive a consult that does not necessarily require a physical exam?

Yes, those can be billed using a specific set of CPT codes (99446-99449 and 99451) that indicate “Inter-professional Telephone/Internet/Electronic Health Record Consultations”. These codes are reported by consulting providers who communicate with treating providers regarding a diagnosis or management of a patient’s problem. These services support a team-based approach to care and don’t include physician interaction with the patient.

100% Medicare Payment, 2020		Office	Facility	RVUs (Non-facility/Facility)
99446	assessment and management services provided by a consultative physician, including a verbal and written report to the patient’s treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	NA	\$18.41	NA/0.51
99447	11-20 minutes of medical consultative discussion and review	NA	\$37.17	NA/1.03
99448	21-30 minutes of medical consultative discussion and review	NA	\$55.58	NA/1.54

99449	31 minutes or more of medical consultative discussion and review	NA	\$73.98	NA/2.05
99451	Inter-professional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time	\$37.53	\$37.53	1.04/1.04

It should be noted that code 99451 doesn't include any verbal interaction between practitioners. It can be accomplished with only a written report.

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Disclaimer: *Billing regulations, particularly during the Covid-19 PHE, are an ever-evolving area. The recommendations provided in this document are based on current guidance at the time of writing and could be subject to change.*

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