American Rheumatology Network Telehealth Overview: Caring for Patients during the COVID-19 Pandemic

Updated March 17, 2020

3:00pm

American Rheumatology Network (ARN) members are concerned about safe access to care during the COVID-19 pandemic. The Centers for Disease Control and Prevention (CDC) has recommended use of telehealth, when clinically appropriate, to lessen the risk of disease transmission. CDC recommendations are fluid and rapidly changing, and rheumatologists and rheumatology professionals are encouraged to check these frequently: https://www.cdc.gov/coronavirus/2019-nCoV/index.html.

Many rheumatologists and rheumatology health professionals have little experience with telehealth, and this guide is designed to offer an overview. Specific information regarding reimbursement varies from state to state and between insurance providers. Therefore, this guide does not address the specifics of reimbursement outside of general policy changes occurring or anticipated from the Centers for Medicare and Medicaid Services (CMS). Rheumatologists and rheumatology professionals are encouraged to check their individual contracts for details on reimbursement. The information contained within this document is accurate at the time of publication.

Telehealth Visit- *Updated Section*

As of 12:30pm ET on March 17, 2020 CMS has sent out an official notification stating that effective for services starting March 6, 2020 (retroactive), the limitations on where Medicare patients are eligible for telehealth services has been removed during the emergency. The waiver temporarily eliminates the requirement that the originating site must be a physician's office or other authorized healthcare facility and allows Medicare to pay for telehealth services when beneficiaries are in their homes or any setting of care.

While traditionally, a HIPAA compliant telemedicine platform has been required and it may be best, if possible, to use such a platform for safety, security, and compliance with applicable state laws, the new waiver in Section 1135(b) of the Social Security Act explicitly allows the Secretary to authorize use of telephones that have audio and video capabilities for the furnishing of Medicare telehealth services during the COVID-19 PHE. In addition, effective immediately, the 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 through everyday communications technologies, such as FaceTime or Skype, during the COVID-19 nationwide public health emergency.

For more information: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/index.html

For billing purposes, the Office Outpatient E/M codes would still be used (99201-99215) and the claim should reflect the Place of Service (POS) code 02-Telehealth, which will indicate that the services were furnished as a professional telehealth service from a distant site.

The use of telehealth does not change the out of pocket costs for beneficiaries with Original Medicare. Beneficiaries are generally liable for their deductible and coinsurance; however, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

The documentation should reflect that the visit was performed via telemedicine and the typical Office E/M documentation guidelines are still to be followed. This service is considered the same as an in person visit and for the time being Medicare will pay the same amount for telehealth services as it would if the service were furnished onsite and in person.

Medicare Telehealth Frequently Asked Questions, Updated March 17, 2020: https://www.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

March 17, 2020 Medicare Telemedicine Health Care Provider Fact Sheet

Telephone Services

AMA and CMS have established CPT and HCPCS codes for reporting evaluation and management services provided by phone. These codes are reported based on time, so rule number one: providers must document the time spent rendering the service. The rest of the rules can be seen in the code descriptions.

"*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 services provided within the previous 7 days not leading to an E/M service or procedure within the next 24 hours or soonest available appointment;*

99441 – *5-10 minutes of medical discussion*

99442 – *11-20 minutes of medical discussion*

99443 – *21-30 minutes of medical discussion'*

- The call must be initiated by the patient
- These can only be reported by providers licensed to render E/M services
- The patient must be established to the practice
- The visit cannot be related to an E/M service provided in the last 7 days

- The visit cannot trigger a face-to-face visit within 24 hours or the soonest available appointment

For Medicare patients, these services are reported with:

G2012 - *brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, 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*

- The rules for 99441-99443 apply
- In addition, "The patient must verbally consent to using virtual check-ins and the consent must be documented in the medical record prior to the patient using the service."

Other Communication-Based Technology

Meaningful Use regulations required that providers establish a secure portal for communicating with patients. If your organization is successfully using your patient portal, there are codes that can be reported to be paid for the work done. There are requirements to use these codes.

"Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;

99421 – *5-10 minutes*

99422 – *11-20 minutes*

99423 – *21 or more minutes*

- The serviced must be initiated by the patient
- These can only be reported by providers licensed to render E/M services
- The patient must be established to the practice, but the problem can be new
- If the work takes under five minutes, it is not reported.
- Time cannot be counted twice or billed for under another, separate code.
- The time cannot be related to an E/M service provided in the last 7 days
- If a separate E/M face-to-face visit or real-time virtual visit occurs within the seven-day period, then this online work is incorporated into the face-to-face visit and not separately reported.
- The time is cumulative over the 7 days and begins when the provider reviews the online generated inquiry

The work included in these services is:

- Review of patient record and data pertinent to assessment of the problem.
- Development of a management plan.
- Generation of a prescription or test order.
- Any subsequent online communication that does not include a separately reported E/M service.

For Medicare patients, report the codes above.

All the services we have discussed so far must be rendered by a physician or other Qualified Healthcare Provider (QHP), but what about the work of qualified nonphysician health professionals? Fortunately, there are codes for this, keeping in mind the rules above when reporting these services.

"*Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days;*

98970 – *5-10 minutes*

98971 – *11-20 minutes*

98972 – *21 or more minutes"*

The corresponding codes for Medicare have a slightly different code description.

"*Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days;*

G2061 – *5-10 minutes*

G2062 – *11-20 minutes*

G2063 – *21 or more minutes"*

At this time, despite the COVID-19 pandemic, CMS has not relaxed the requirements for telehealth visits provided to traditional Medicare patients, but the fact sheet released this week does address Medicare advantage plans separately. This states, "Medicare Advantage plans may provide their enrollees with access to Medicare Part B services via telehealth in any geographic area and from a variety of places, including beneficiaries' homes. With this flexibility, it is possible that beneficiaries in Medicare Advantage plans can receive clinically appropriate services for treatment of COVID-19 via telehealth." Check with your carriers to get specific guidance about this.

Also, new information is being reported daily in response to COVID-19, so stay tuned to information being provided by CMS about any possible relaxation in the requirements for traditional Medicare telehealth services.

This guide will be updated periodically as the situation and guidance evolves, so please check back frequently.

An excellent, brief video introduction to the use of telehealth is available at the following link (courtesy of Dr. Carolynn Francavilla):
https://www.youtube.com/watch?v=k0lEhH7YOm4&feature=youtu.be

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About American Rheumatology Network

American Rheumatology Network ("ARN") is a physician led and owned organization committed to improving healthcare by empowering independent rheumatology practices across the nation. Through our network physicians and practice administrators have access to best business practices, innovative practice performance technology, and value-based treatment pathways. Please visit our website at americanrheum.com for more information.