TELEHEALTH - GUIDE TO DOCUMENTATION, ETHICS AND INSURANCE

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I have no relevant financial relationships with any ACCME-defined commercial interest to disclose.

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DOCUMENTATION, ETHICS, INSURANCE

CORE TELEHEALTH PROGRAMS

- Portal Messaging
- eConsults
- Ambulatory Visits
  - Phone
  - Video
- Inpatient Consultations
- Remote Patient Monitoring

PORTAL MESSAGING

- Not part of current CMS waiver – these are permanent
- Must be patient-initiated from phone call or portal message
- Consent must be documented
- Time is cumulative over 7-day period
- <u>Covered only by Medicare, Medicare Advantage, and UHC</u>
  - No wRVUs will be applied for other payers (BCBS, etc.) at this time

MUST HAVE CONSENT

By utilizing myUABMedicine, I consent to all telemedicine services related to the patient portal. Extended portal message conversations with my provider(s) may result in billable services to my insurance, including copays and deductibles if applicable.

If you don't own or control the computer you're using, turn on "private browsing" to protect your personal health information.

E-VISIT CODES ARE CUMULATIVE OVER 7 DAYS

- G2012 (Virtual Check-in) – 5-10 minute phone call in response to patient
  - wRVU 0.25
  - $14.80
  - **Not originating from a recent visit (7 days prior) or leading to an E&M in the next 24 hours**

- 99421 (Online e-visit) – 5-10 minutes portal communication over 7 days
  - wRVU 0.25
  - $15.52

- 99422 (Online e-visit) – 11-20 minutes portal communication over 7 days
  - wRVU 0.50
  - $31.04

- 99423 (Online e-visit) - >20 minutes portal communication over 7 days
  - wRVU 0.80
  - $50.16

DOCUMENTATION

- You must document the cumulative time spent on the portal message response
- CPT code related to the portal message
- ICD-10 code

INSURANCE CHALLENGES

Insurance

- Difficult to verify time spent on portal message
- Electronic charge capture is difficult due to need to create an “on-demand” encounter
- May not be billable by all insurers

Ethics and Regulatory

- Every portal message is not billable
- Can you answer a portal message if a patient is located in a state that you do not hold a medical license?

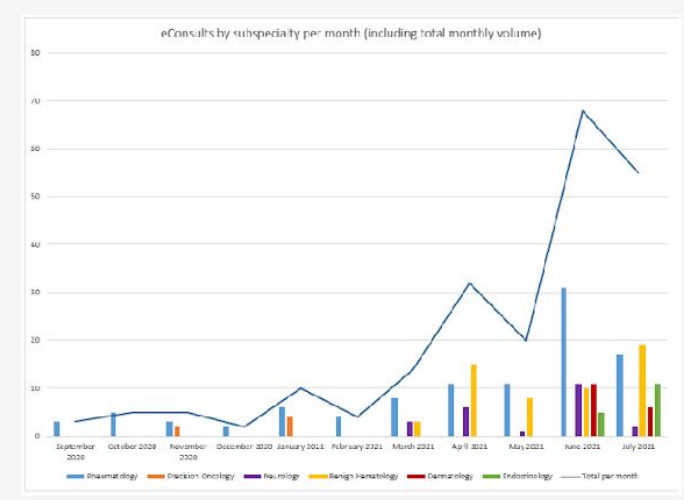
ECONSULTS

ECONSULTS

- Very useful for quick consultations not requiring an in person visit.
- Less expensive than an inperson visit and makes it ideal for value based care
- Improves access to care by opening up slots for patients with more complex problems

ECONSULTS

- You must document that patient consent was obtained.
- Patient will be responsible for applicable copay/cost share.
- The same specialty cannot bill for an eConsult and an Office Visit within 14 days. The billing system will kick out the last charge submitted if this occurs.
- Have to document greater than 5 minutes spent reviewing chart and document the consultation.



ECONSULTS

- If Referring/Treating Provider spent 16 minutes or more preparing eConsult request and communicating with the Consulting Provider they can bill for their service.

INSURANCE/REGULATORY/ETHICS

Insurance

- Covered by CMS but may not be covered by all insurers
- Some insurers may reimburse primary care provider for spending more than 16 minutes implementing plan

Regulatory

- Must consent the patient and ensure they know of potential co-pays
- Can you do an eConsult for a patient who lives out of state?

Ethics

- Should all consults start as eConsults

SCHEDULED TELEVISITS

STATE LICENSURE

- Practice of medicine occurs where the patient is at the time of the visit
- Providers must have a license in the state where they practice
- As such, providers cannot practice telehealth across state lines unless
  - A. The patient drives into the state where the physician is licensed
  - B. The physician is licensed in the state where the patient is located at the time of the visit
  - C. State of emergency exists that allows for emergency licensure
    - May only apply directly to the care of Covid patients
- This is not a billing issue

INSURANCE

- Billing Codes CMS
  - Category 1 codes are here to stay
  - Category 2 are scheduled for elimination
  - Category 3 Codes will expire the last day of the year of which the PHE expires
- Outpatient Codes
- Audio only: 99441-99443
  - Some private insurers allow the Video New and Video Return Codes
  - During PHE reimbursed at same rate as level
- Video New: 99201-99205
- Video Return: 99211-99215

PHONE BASED

- Audio only: 99441-99443
  - During PHE reimbursed at same rate as level as a
    - 99212 5-10 minutes
    - 99213 11-20 minutes
    - 99214 21-30 minutes
    - Does not reimburse at a new patient rate even if patient is new
    - Only reimbursed for Medicare based on time
    - Time must be documented.

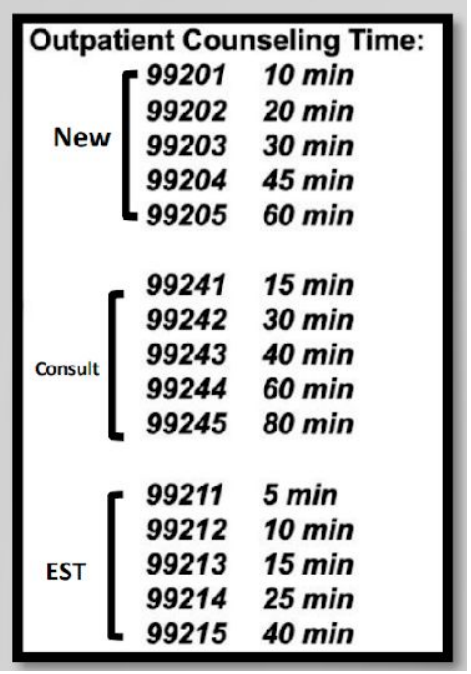
CMS PROPOSED RULE

- We are seeking comment on whether a different interval may be necessary or appropriate for mental health services furnished through audio-only communication technolog
- Limit the use to where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology

https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule

VIDEO BASED

- Documentation for video same as for in-person
  - Continue using 1995 and/or 1997 guidelines.
  - Base the level of services solely on medical decision making (MDM)
  - Choose the level based on total time of the visit, not just when 50 percent is spent in counseling and coordination of care.



https://www.ismanet.org/ISMA/Resources/e-Reports/3-6-1
ative.aspx

MEDICAL DECISION MAKING

Type of Decision Making	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity/ Mortality
Straightforward or Minimal	Minimal (1)	Minimal or None (1)	Minimal
Low Complexity	Limited (2)	Limited (2)	Limited
Moderate Complexity	Multiple (3)	Moderate (3)	Moderate
High Complexity	Extensive (4)	Extensive (4)	High

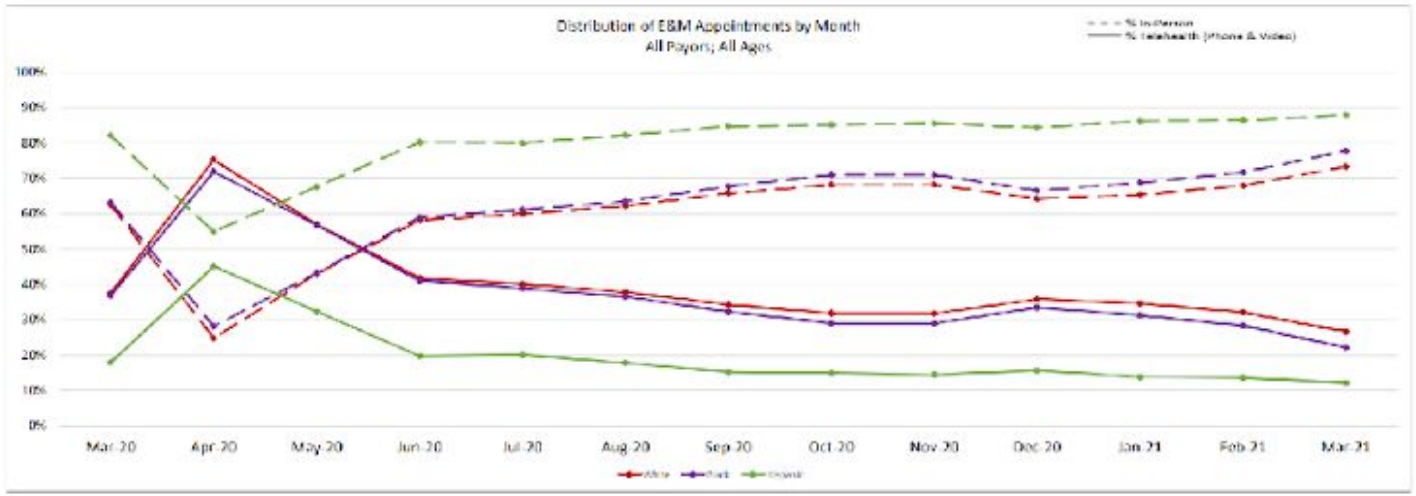
https://codingintel.com/a1-medical-decision-making/

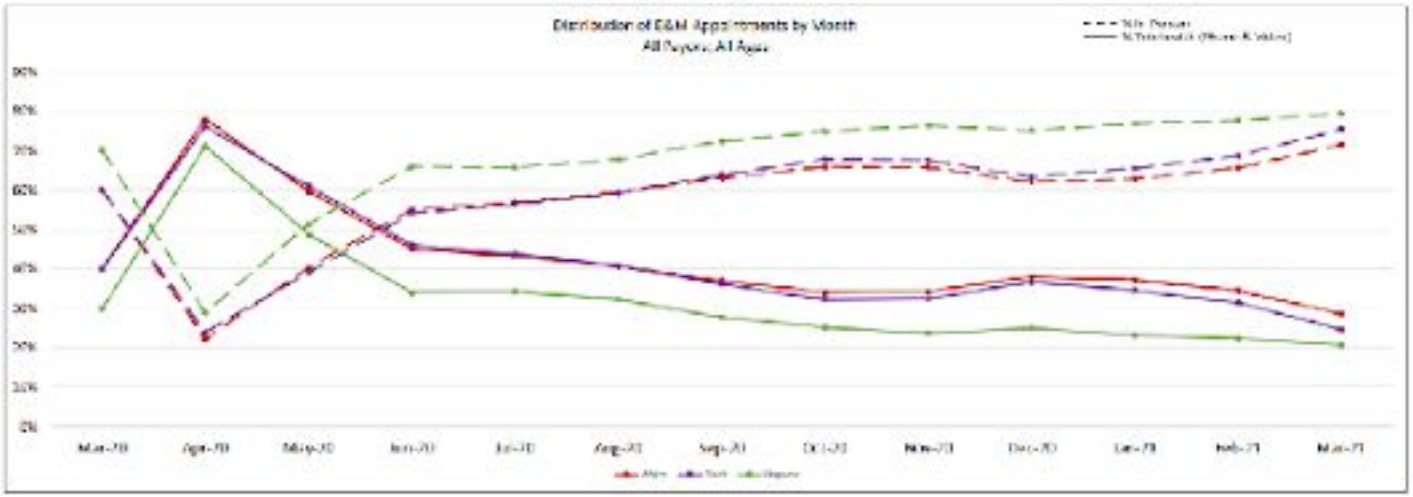
ORIGINATING SITE FEE

- Q3014
  - Patient is at originating site
    - Originating site bills
  - Patient is at home during the pandemic/physician is part of a hospital based clinic
    - Clinic that is supporting that visit can bill the Q3014

- G0463
  - Lots of confusion

DISPARITIES





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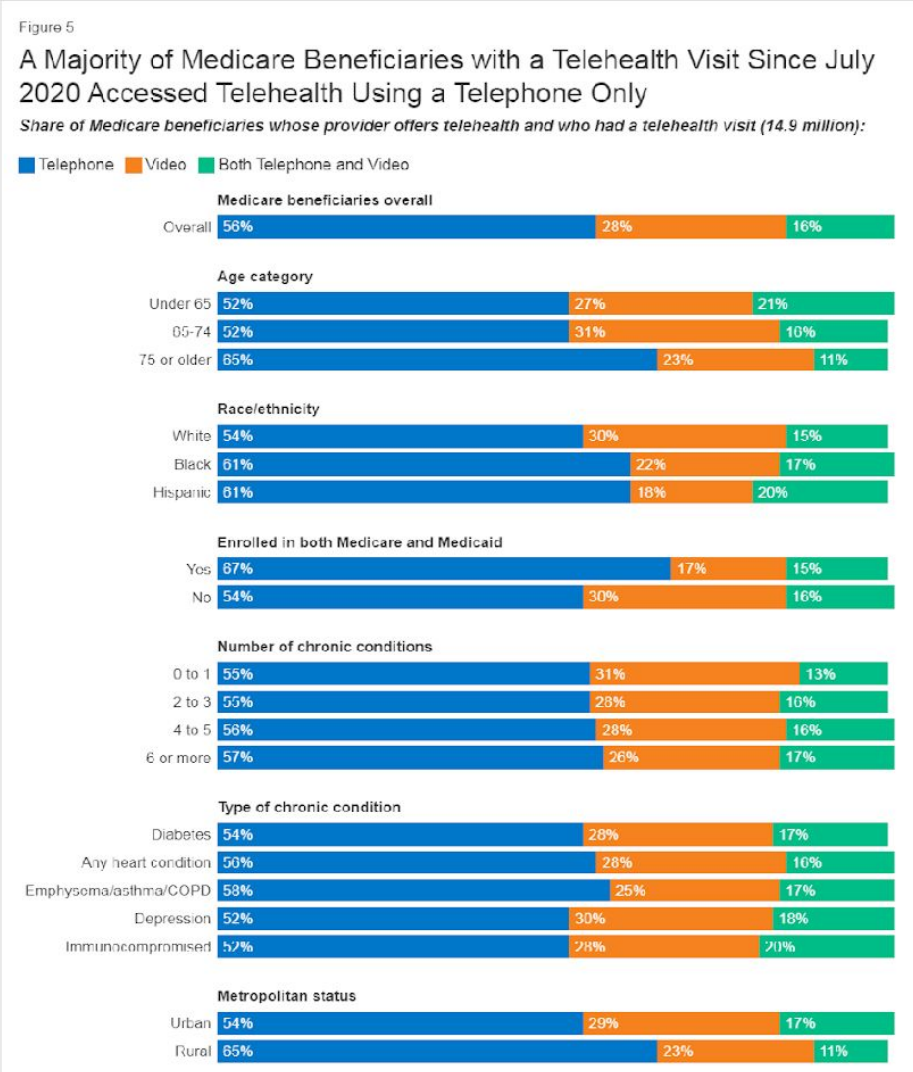
Unpublished UAB data

DISPARITIES



https://www.kff.org/medicare/issue-brief/medicare-and-telehealth-coverage-and-use-during-the-covid-19-pandemic-and-options-for-the-future/

BEST PRACTICES

- Patient educators
- Telehealth Score
  - Patient portal (Y/N)
  - Have you had a telehealth visit before (Y/N)
- Public Wifi access points

REMOTE PATIENT MONITORING

REMOTE PATIENT MONITORING

- Planning is of utmost importance
  - Who are you going to monitor?
  - What are you going to monitor?
  - What are you going to do with alert values?
  - How are you going to get the data back to the patient and intervene?
  - How are you going to resist the urge to default to “Go to the ER”
  - How long are you going to monitor patients?
- Everything that can be measured can be monitored. Everything that can be monitored can be monitored remotely. This does not imply that anything and everything should be monitored remotely.

MUST HAVE IRONCLAD CONSENT

- Insurance will be charged and you may have a co-pay
  - Co-pays for this should really be removed (write your congressman)
- This is not telemetry. Patient's who need telemetry need the hospital.
- This is for ambulatory monitoring and use of trends not for emergency care.
- If you monitor enough patients someone will pass away after taking vitals. As such, need the consent to be done well.

REMOTE PATIENT MONITORING

- 99453- Initiation
- 99454
  - Provision of equipment
  - Transmission of 16 calendar days of values
- 99457
  - First 20 minutes cumulative of incident to nursing time
- 99458
  - Second 20 minutes of cumulative incident to nursing time

- 99091
  - Remote collection of data such as EKG's.
  - Must take 30 minutes to interpret

REVENUE FLOW

- All of it can go to the group doing the monitoring
- The provider requesting the monitoring can contract with the company for the monitoring services who then grants back privileges for the primary provider to bill.

REMOTE THERAPEUTIC MONITORING

- Proposed codes

- 989x1-989x5
  - Don’t have to be physiologic data
    - Patient reported outcomes
    - Can be manually input

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https://www.foley.com/en/insights/publications/2021/07/cms-new-remote-therapeutic-monitoring-codes

ETHICS

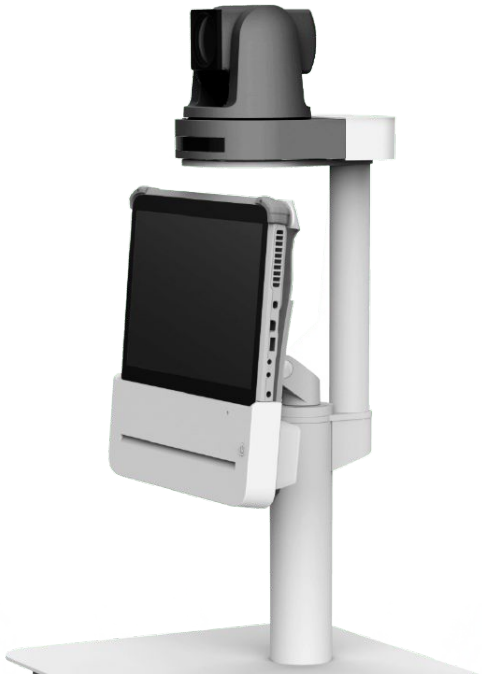
- Responsible use of remote patient monitoring
- Really need to ensure patients that are going to benefit from it are the ones being monitored.
- Not everyone needs a monitor and very few people will need or tolerate being monitored forever.

CROSSING STATE LINES

- Can’t cross state lines
  - Confusion at the beginning of COVID
  - Each state has the right to choose to let other providers practice in their state
- The rules make no sense any more
  - Can I answer a portal message across state lines
  - Can I call a patient across state lines
  - Is it just for new patients?
- We need to re-examine things and put in place rules that make sense
- Some states have an “irregular practice” of medicine (ie. Less than 10 calendar days in the case of Alabama”

INPATIENT

INPATIENT



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UTILITY

- Improves access to care
- During COVID- patients are stuck as there are no beds in tertiary referral centers. As such, telehealth is a necessity
- Outside of the pandemic
  - Improves the number of patients that stay safely in a rural facility
  - Improves quality of life of providers at those facilities (critical care)
  - Improves economics of rural hospitals and urban alike

REGULATORY

- Doctors must be privileged at every hospital they are providing care at
- Credentialing-by-proxy agreements help
- Documentation must live in the EMR where the patient is located

INPATIENT

- Primary Team (Tele-hospitalist programs)
- 99221-99223: Initial hospital E/M service, per day, new or established (Outside of PHE was only billable once every 3 days)

- Subpecialty consultations

- G0425-G0427: Consultations, emergency department or initial inpatient (Medicare only)
- G0406-G0408: Follow-up inpatient telehealth consultations for patients in hospitals or SNFs (Medicare only)
- Billable daily

FULL TELE-ICU

- Every room is wired
- Critical care billing is largely based on time
- It is billable but most providers are not reaching the time needed to bill critical care
- Really a sad reality that in a time where people need to be efficienc, billing penalizes the critical physicians

ETHICS AND BEST PRACTICES

BEST PRACTICES

- Make sure adequate time is spent with patient
- Look at the camera
- Ensure that telehealth is adequate to address the issue
- Telehealth is not “Fast Medicine”
- Make sure you are not back lit
- Take time to analyze your workflow
  - Telehealth can be efficient
  - Providers that are having trouble need to analyze workflow
- Patients should be the one having the choice

ETHICS

- Is it ethical for states to have laws that limit access to care for patients?
- It is unethical to bill on time when time wasn't spent
  - This will likely be audited in the future

INSURANCE

CMS PROPOSED RULE

- CMS has limited authority
  - Psychiatry allows for removal of geographic and originating site restrictions
  - Plans to limit audio only use
  - No mention of reimbursement changes for audio only
- What it lacks
  - Geographic restriction removal for anything but psychiatry
  - Originating site as the home for anything but psychiatry
- Why?
  - Those things have to be legislated
  - Contact your representative and tell them to get legislation passed ASAP

STATE BY STATE REGULATIONS

- Federation of state medical boards
  - https://www.fsmb.org/
- National Telehealth Policy Resource Center
  - https://www.cchpca.org/

FUTURE

- We have an unprecedented ability to expand our reach both in the Outpatient and Inpatient worlds
- We must learn about and implement technology in a way that
  - Improves Clinical Outcomes
  - Improves Work Efficiency
  - Decreases Cost
- We must continue to transform what we do, to do it better and with less cost.
- If we don’t others will do it for us.