"Getting Online with Telehealth: Practical Guidance for Physician Practices"

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Additional Questions & Answers:

Disclaimer: To the best of our knowledge, these answers were correct at the time of publication. Given the fluid situation, and with rapidly changing new guidance issued daily, be aware that these answers may no longer apply. Please visit our COVID-19 hub frequently for the latest information, as we are working diligently to put forth the most relevant helpful guidance as it becomes available.

Q: How do you document the exam part of a new patient visit on a telehealth visit?

A: The physician or NPP should determine what is medically necessary to examine based on the presenting problem and document the exam elements he or she is able to perform based on the limitations of the remote assessment. If the physician is leveraging a telehealth solution, the patient might be provided with certain tools to capture examination data, such as thermometer, stethoscope, tongue depressor, etc. Physicians should review their medical specialty society and state medical association clinical practice guidelines for telemedicine exams.

Q: Is the Medicare once every 7 days restriction for telehealth services in place?

A: We are not aware of a limit for the number of telehealth services in a given time period as long as they are medically necessary services. E-visits are reported for the cumulative time spent for seven days.

Q: If a provider wants to bill for telehealth services performed when the provider is at home, is the provider REQUIRED to call the hotline number and enroll the provider's home as a site location? I assume so but have heard conflicting information.*

Q: Could you please cover the provider's home information? Is there a CMS guideline that addresses providers rendering telemedicine from the provider's home?*

Q: We have heard that a provider can perform telehealth from their personal home, but that the "normal face:face clinic" location should be on the 1500 claim. However the CMS FAQ states that the address has to be added to the 855A. Do you have a copy of guidance you are using saying that we can use the normal clinic address?*

Q: Excluding the current COVID19 emergency; are providers required to notify their MAC that they provide telehealth services whether that be their office location or home?*

*All of these questions have the same answer:

A: Here is the guidance CMS provided on March 27:

> 11. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?

There are no payment restrictions on distant site practitioners furnishing Medicare telehealth services from their home. The practitioner is required to update their Medicare enrollment with the home location. The practitioner can add their home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline. It would be effective immediately so practitioners could continue providing care without a disruption. More details about this enrollment requirement can be found at 42 CFR 424.516.

If the physician or non-physician practitioner reassigns their benefits to a clinic/group practice, the clinic/group practice is required to update their Medicare enrollment with the individuals' home location. The clinic/group practice can add the individual's home address to their Medicare enrollment file by reaching out to the Medicare Administrative Contractor in their jurisdiction through the provider enrollment hotline.

Q: When documenting time, is the time based on the time the physician spent on the video/phone with the patient or should it include the documentation review time as well.

A: Document the time on the video, as that will be considered the face-to-face time.

Q: Where can we find the information on FQHC's you referred to in your opening?

A: The expansion of Medicare telehealth coverage to include RHC and FQHC services is found in Section 3704 of the CARES Act. The legislation directs CMS to develop methodology for reimbursing RHCs and FQHCs. There is no specific timeframe for CMS to stand up this process. Keep in mind that RHCs and FQHCs presently can bill for telehephonic virtual check-ins under HCPCS G0071.

Q: Any guidance for consulting providers in the hospital setting who are asked to consult on r/o COVID cases...MD reviews the hospital record, orders diagnostic labs/imaging, formulates a plan, but does not physically see the patient.

A: Use 99446-99449, 99451-99452 for interprofessional consultations. Read thoroughly the coding guidance for these codes as some require half the time in interactive consultation, where 99451 is reported based on the total review and communication time. Confirm payer coverage for these codes.

Q: For an internal medicine practice, what elements of a physical exam and we perform in telemedicine? Can we ask a patient to aid in the exam, i.e., take pulse, press on abd,, etc

A: We recommend reviewing your specialty medical society guidance for effective telemedicine visits.

Q: I am a Nurse Practitioner working in a Rural Health Clinic attached to a CAH. My question is twofold. Is it still true even with the new waiver from CMS that I as the provider need to be physically on the CAH side when conducting telehealth visits with patients who are at home? Secondly, I am still waiting to be approved for payor enrollment with Medicare. Is there any word that this will be expedited for new providers who are still awaiting payor enrollment approval?

A: Here is the guidance CMS provided on March 27:

> 11. Can the distant site practitioner furnish Medicare telehealth services from their home? Or do they have to be in a medical facility?
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CMS has established an expedited enrollment process for physicians, nurse practitioners, and physician assistants. For more information, please visit https://www.cms.gov/files/document/provider-enrollment-relief-faqs-covid-19.pdf

Q: For minors (children), will a new consent be needed each time telehealth services are provided for a child. Or, can the consent done at the beginning of treatment cover continued treatment for that child? Are there exceptions (patient age groups 12-17) that do not qualify for video visits?

A: State law consent-to-treatment rules apply to telehealth in the same manner as they apply to face-to-face visits.

Q: Can RHC's now bill for telehealth?

A: The expansion of Medicare telehealth coverage to include RHC and FQHC services is found in Section 3704 of the CARES Act. The legislation directs CMS to develop methodology for reimbursing RHCs and FQHCs. There is no specific timeframe for CMS to stand up this process. Keep in mind that RHCs and FQHCs presently can bill for telehephonic virtual check-ins under HCPCS G0071.

Q: How do we comply with ADA requirements when using telehealth?

A:

- Assess the individual's needs as well as the benefits and risks of using technology to provide services.
- Consider the products, services and environmental factors that are required to provide effective telehealth services to the consumer.
- Become aware of existing barriers for the individual with disability. Work to remove these barriers.
- Consider the compatibility of phones, equipment and computer-based programs used by the consumer and whether the products can work effectively with your method of service delivery.

- When using home-based or consumer technology, be mindful of the needs of your consumer regarding website accessibility, captioning and assistive technology and equipment.
- Learn about accessibility features and functions on software programs and apps that you might use.
- If services are provided via a telehealth center, be mindful of the needs of your consumers (e.g., access for wheelchairs and power-driven mobility devices, service animals, use of video relay interpreters, use of assistive technology and equipment).
- Work with an assistive (adaptive) technology professional or rehabilitation engineer if necessary.
- Be mindful that some individuals with disability work closely with a family member, caregiver and/or home health care provider. What is the role of this person, if any, in the consumer's treatment? Consider the potential impact this may have on the provision of services.
- Develop a specific plan with the consumer that addresses emergency and/or unusual situations. If an emergency arises, ensure that the consumer knows of a local hospital, clinic, and/or professional equipped to provide them the appropriate support or care.
- Increase awareness and skills related to cultural competency and linguistic sensitivity.
- Working with an individual with a disability? Unsure about their needs? Just ask.

Q: Thank you for hosting the seminar, it was well put together and insightful. I asked a question surrounding the impact of incident to and telehealth. I know there was a brief comment here but I was wondering if there has been any additional clarity surrounding this subject. Please let me know if PYA has received clarity related to incident to billings.

A: If a physician and NPP are 1) in the same office suite, 2) the NPP performs a telehealth visit for a Medicare patient who is established, and 3) the conditions addressed and treatment plans were established by a physician, it would seem reasonable that the service could be billed under the supervising physician under the incident to guidelines. However, there is no specific guidance regarding this specific scenario. In CMS' recent interim final rule, it states, "For telehealth services that need to be personally performed by a physician, such as an E/M visit, the physician would need to personally perform the E/M visit and report that service as a Medicare telehealth service." Because this statement could be interpreted that incident to is not permitted, it is recommended that you bill under the NPPs NPI. If the patient is a new patient, presents with a new problem, or is a member of a plan which does not recognize incident to guidelines, bill under the NPPs NPI for those plans that credential NPPs and the physician's NPI for those that do not.