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Telehealth and E-Visits- Make It Work For You

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Types of Virtual Services

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Types of Virtual Services

- Telehealth visits
- Virtual check-ins
- E-visits

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TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient. **Does not include therapy practitioners at this time**	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

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Telehealth Visits

- Currently, therapy practitioners are not able to bill Medicare for Telehealth visits
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits
- Coinsurance and deductible would generally apply to these services

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NOT Telehealth Visits

- During an Open Door Forum call with CMS on April 8, 2020, the question was raised as to whether telehealth services could be utilized when a clinician and a patient were at the same location but not able to be in same room for treatment due to COVID-19-related reasons.
- On April 10, 2020, CMS released guidance in response to the question.
  - ***Question: Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?***
  - ***Answer:*** Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a "distant site"), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished. New: 4/9/20 FAQ (page 22 question 9)

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E-Visits

- The patient must generate the initial inquiry and communications can occur over a 7-day period
- E-visits are NOT the same as telehealth or telerehab services
- Coinsurance and deductible would apply to these services

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E-Visit Billing

- Clinicians who may not independently bill for evaluation and management visits (for example – physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:
  - G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
  - G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
  - G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

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State Law / Payer Policy

- First, check state practice act
  - Can you provide telehealth or other virtual care services by law?
  - Licensure (or compact privilege)
- Then, check payer policy
  - Private payers vs. Medicare
  - Confirm the rules with each payer. (These rules are changing rapidly in some cases).

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Telehealth and HIPAA: Updates from OCR Amidst COVID-19

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Telehealth and HIPAA: 1135 Waiver

Office for Civil Rights (OCR) has **temporarily relaxed enforcement of HIPAA regulations**
in response to the public health emergency [using an 1135 waiver]

PROFESSIONAL JUDGEMENT
Use professional judgement & conduct tele-services in a private space to avoid any potential breach of privacy

CONSENT
Consent is needed and must be documented **prior to initiation** of telehealth services + seek verbal consent **at start of every service**

START OF EVERY SERVICE
Provider should seek verbal consent at start of every service

GOOD FAITH EFFORT
If a privacy breach occurs*, OCR will not enforce penalties as long as good faith effort was made to protect PHI

*State privacy laws may supersede this waiver. Check state-specific laws for further guidance.

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Telehealth & HIPAA: Platforms

Covered health care providers should **utilize platforms that are HIPAA-compliant**
to their best effort whenever possible

USE platforms that provide HIPAA-compliant video or platforms entering into a HIPAA BAA.
EXAMPLES INCLUDE:

Skype for Business | Google G Suite | GoTo Meeting | Zoom for Healthcare | Cisco Webex | Amazon Chime

AVOID public facing communication platforms for any services.
EXAMPLES INCLUDE:

Facebook Live | Twitch | TikTok

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Virtual Care in Acute Care

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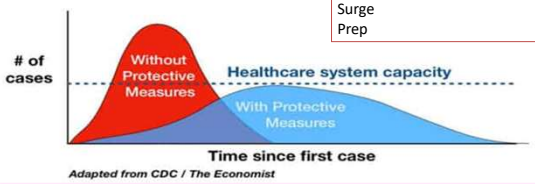
Remote access in Acute Care

Preparing for the possibility of a worse-case scenario if we are not able to flatten the curve

Phase 1	Phase 2	Phase 3
Support Measures to Flatten Curve + Surge Prep	Support Meeting of Clinical Needs	Support Active Recovery



Adapted from CDC / The Economist

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Phase 1 – Support Efforts to Flatten the Curve & Surge Preparation

- Mobilize our faculty, staff, and students
  - Telecommute for non-onsite activities
  - Shifts in teams (4 days on, 3 days off)
- Tele-commuting workforce:
  - In-services and training materials
  - Help with administrative tasks
  - All off-site activity maximized
  - Build our infrastructure for telehealth services

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Phase 1 – Support Efforts to Flatten the Curve & Surge Preparation

- Remote access to facilitate throughput:
  - Discharge home rather than post-acute care
  - Challenges with access to outpatient
  - Census management
- Telehealth
  - Telephonic access to patients and families
  - Telehealth for remote Care-giver training (No Visitor)
  - Telephonic/Telehealth/E-visits for continuity of care (I/P to home or to O/P)

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Phase 2 – Support Meeting Clinical Needs During Crisis

Prioritization of patients for telephonic/telehealth inpatient acute

- High priority patients (PUI, COVID+, General Acute):
  - Capable of discharge home soon to increase admission capacity: therapeutic intervention, patient education, care-giver training
  - OT, PT, and SLP are essential for safe and effective through-put
- Medium priority patient:
  - Capable of discharge to home or facility, not as soon.
  - Cannot tolerate as much therapy
  - Cannot connect with care-giver for training
- Low priority patient:
  - Will not be able to discharge soon due to medical complexity, no D/C destination, patient that is not appropriate for therapy at this time

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What to expect when seeing COVID+ patients

	Clinical Features	Client Factors / Needs
Stage 1: Early Symptoms *Mild Disease*	Fatigue, shortness of breath, fever * pre-hospital/hospital admission	**Fall risk** **Risk for readmission** **Community supports for successful *shelter at home*** **Mental health**
Stage 2: Respiratory Distress *Moderate Disease*	Hospitalization Hypoxia, on supplemental oxygen Supportive medical therapy	Prevent physical deconditioning Functional endurance **Mental health** **Occupational deprivation**
Stage 3: Respiratory Failure *Severe Disease*	ICU Admission Mechanical Ventilation Sedation, paralytics, prone-ing ARDS-like presentation Vent weaning	ICU-Acquired weakness **Delirium** Physiologic tolerance for gentle mobilization **Monitor for further decompensation**
Post-Acute Care Recovery *Recovery from severe disease*	Post-intensive care syndrome Physical, cognitive and psychological dysfunction Post-acute care rehabilitation	Post-intensive Care syndrome ICU- acquired weakness Vent/O2 weaning **Cognitive impairment** **PTSD, anxiety disorders**

Jamie Wilcox, OTD, OTR/L 04/01/2020

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Cognitive impairment and delirium risk

- Telehealth and telephonic access gives you another way to continue to check-in and monitor patients
- Remote interactions with patients and connecting patients to family can help address orientation, promote environmental adaptations, facilitate social connectivity to help mitigate the negative impact of extended critical illness and extended hospitalizations

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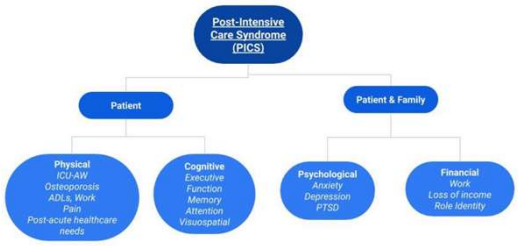
https://www.sccm.org/MyICUCare/THRIVE/Post-intensive-Care-Syndrome



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Isolation and deprivation

Consequences of “flatten the curve” measures already occurring with inpatients

- Social isolation, boredom, loneliness, and anxiety for inpatients due to “No Visitor Policy” & bedside staff reducing contact time
  - Telehealth bridge:
    - To outside world, family, friends, skilled therapists who can address increased risk for mental health sequelae due to extended isolation
    - Positive impact on psychosocial health and recovery
    - Help clients establish habits, roles and routines to combat occupational deprivation

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Phase 3 – Support Active Recovery

- Continued throughput of non-COVID and COVID+ patients with Mild disease
  - Leverage telehealth/telephonic to support
    - Rehabilitation focused interventions
    - Support rapid discharge to home as able
- If increase in census
  - Begin transition back to pre-pandemic therapy roles of active rehabilitation and pre-habilitation for patients in all levels of care
    - Critical Care > Step-down > Medsurg > Post-Acute (ARU, OP, etc.)
  - Work to adapt successful pandemic-time telehealth services into routine service workflow and capacity

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Discharge Considerations during a Pandemic

- Community resources
- Caregiver availability
- Access to groceries, pharmacy, follow-up appointments
- Outpatient or home health follow-up
- High Risk for Readmission

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General Guidelines for the Different Groups of Patients Receiving Telehealth/Telephonic OT or SLP services

	INPATIENTS	*INPATIENTS POST-DISCHARGE (NO FORMAL OP REFERRAL)*	*EXISTING OUTPATIENTS*
PROVIDER OF SERVICES	OTD Residents	OTD Residents	OT, SLP, or OTD Residents
DOCUMENTATION	Inpatient OT Progress Note (files with Multidisciplinary Rehab Documentation so that IP therapists can see what's being communicated with the patients) *If patient discharged from OT service, but remains in the hospital, use Consult Note	Consult Note (files in Diagnostic Therapeutic Records, where OP documentation usually gets scanned into)	Consult Note (files in Diagnostic Therapeutic Records, where OP documentation usually gets scanned into)
POC	Sessions provided by OTD residents are supplemental to POC; do not count towards meeting frequency	No formal POC	Functioning under existing POC
OUTCOME MEASURES	OTD residents to administer outcome measures (E.g., PROMIS-Global Health Scale, diagnostic specific measures) at first IP telehealth visit, and last IP telehealth visit	OTD residents to administer outcome measures (E.g., PROMIS-Global Health Scale, diagnostic specific measures) at first telehealth visit post-discharge, and last post-discharge visit	OTD residents to administer outcome measures (E.g., PROMIS-Global Health Scale, diagnostic specific measures) at first telehealth visit, and last OP telehealth visit OTs, SLPs, & OTD residents to complete outcome measures as per usually done with your OPs (if any)

Phuong Nguyen, OTD, OTR/L, 04/16/2020

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Ethics, Safety, and Liability

- Educate therapists about their responsibility/liability as telehealth providers in any setting
  - Be mindful of what you are asking patients to do during telehealth sessions, and consider any safety considerations (e.g., fall risk, hypertensive/hypotensive episodes, depression & suicidal ideations)
  - If a patient is in imminent danger, call for help (code or 911)
- Telehealth/telephonic documentation:
  - Patient understanding of the purpose and nature of the session, and verbally agrees or consents to proceeding with telehealth/telephonic session
  - Patient's disposition related to safety and privacy
  - Quality of interface (audio/visual quality, internet connection stability/disruptions, duration of any disruptions)
  - Patient's response to the session
  - How you left the session

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Skilled Nursing Facilities (Part A Benefit)

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Skilled Nursing What we know about risk

- **Based upon available information to date, those at high-risk for severe illness from COVID-19 include:**
- People 65 years and older
- **People who live in a nursing home or long-term care facility**
- People of all ages with underlying medical conditions, particularly if not well controlled, including
- **People with chronic lung disease or moderate to severe asthma**
- **People who have serious heart conditions**
- People who are immunocompromised
- People with severe obesity (body mass index [BMI] of 40 or higher)
- People with diabetes
- People with chronic kidney disease undergoing dialysis
- People with liver disease

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Skilled Nursing Facility (SNF) Regulatory Timeline

- April 2nd To avoid transmission within long-term care facilities, facilities should use separate staffing teams for COVID-19-positive residents to the best of their ability, and work with State and local leaders to designate separate facilities or units within a facility to separate COVID-19 negative residents from COVID-19 positive residents and individuals with unknown COVID-19 status.
- April 8th During a national stakeholder call on CMS opened up the possibility that it would allow a clinician to provide services remotely to a patient in the same building, but not in the same room, and bill the encounter as an in-person visit.

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SNF Technology Considerations

- Smartphones or tablets can be used to provide evaluation and treatment, when clinically appropriate, and should be reported as in-person services, not telehealth
- "As long as both patient and provider are in the same building, therapists can bill for services conducted over audiovisual devices as though they were performed face-to-face," Yoder said.

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On-site visits via video or window

- *CMS FAQ*
  - **Question:** Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services? How could a physician or practitioner bill if this were telehealth?
  - **Answer:** Services should only be reported as telehealth services when the individual physician or practitioner furnishing the service is not at the same location as the beneficiary. If the physician or practitioner furnished the service from a place other than where the beneficiary is located (a "distant site"), they should report those services as telehealth services. If the beneficiary and the physician or practitioner furnishing the service are in the same institutional setting but are utilizing telecommunications technology to furnish the service due to exposure risks, the practitioner would not need to report this service as telehealth and should instead report whatever code described the in-person service furnished.

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Remember there is no waiver for "skilled" therapy

- Evidenced Based Practice
- Complexity and Sophistication
- Medical Diagnoses
- Individualized Frequency and Duration

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SNF Clinical Considerations

- Clinical Considerations:
  - Therapists should consider patient abilities, plan of care goals and objectives, use of service for restorative versus maintenance care and ability to collaborate with other in room therapists or nursing teams. For example, consider use of verbal and visual return demonstration and treatments in conjunction with CNAs to effectively train ADL and functional targets
  - Exercise or task-based prescription should continue to be based on individual needs.
  - Remember- interventions still need to be skilled. The intent here is to keep our patients as safe as possible during this time of pandemic

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Virtual Care in Outpatient

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Payer Policy

- CPT codes
- Modifiers
  - GT or 95: Synchronous telehealth services
  - GQ: Asynchronous telehealth services
  - CR: Catastrophe/disaster-related; services provided based on a formal waiver (CMS policy)
- Place of Service (POS) Codes (on 1500 forms only)
  - 02: Telehealth
  - 11: Clinic
  - 12: Home

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Patient Registration / Consent

- Complete patient registration, insurance authorization and verification, notice of privacy practices, etc.
- Obtain consent for treatment – specifically, for telehealth or virtual care services
- Consider copays, coinsurance, deductibles
  - Check for waivers

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Platform / Technology

- Timely implementation vs. planning for the future
- HIPAA-compliant platforms – BAA required
- Technology requirements for each type of virtual service
  - Real time, two-way audio/video technology
  - Online patient portal
  - Telephone

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Using Virtual Care in Practice

- Telehealth – true "virtual visits," in-person services delivered via technology
- Communication Technology-Based Services – not considered a "visit," patient-initiated communication, assessment and management services

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Using Virtual Care in Practice

TELEHEALTH
- Potential to deliver both evaluations & treatments
- Therapists & assistants
- Ability to establish and follow plan of care virtually
- Platform flexibility
- Covered by many commercial payers (but not Med B)

CTBS
- Assessment & management services provided between in-person "visits"
- Therapists only
- Platform dependent on service provided (e.g., phone assessment, e-visit)
- Covered by Med B (but not many commercial payers)

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Documentation

- For Telehealth
  - Patient consented to telehealth, platform/technology used
  - Interventions/skilled services delivered, patient response, assessment of progress (as with "typical" in-person visit)
  - Total treatment time, as applicable
- For Communication Technology-based Services
  - Patient initiated and consented to the service
  - Platform/technology used
  - All communication/actions taken; clinical decision-making of the therapist
  - Time spent providing the service, as applicable

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Example: Telephone Assessment

- 68 yo patient with LBP due to L3 compression fx; chooses to stop in-person PT visits due to COVID-19
- Calls PT with c/o increased pain, inability to sleep
- PT inquires about home program, activity levels; makes recommendations for ongoing exercise/ activity
- Phone call lasts 23 min; bill one unit 98968GP

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Example: Virtual Check-in

- 70 yo patient with wrist pain, stiffness, swelling, decreased ROM s/p Colles fx; chooses to stop in-person OT visits due to COVID-19
- Contacts OT and requests virtual check-in due to increased stiffness and swelling; virtual check-in conducted via Zoom for Healthcare
- OT observes patient's wrist for swelling/redness and AROM, asks about pain level, activity/home program; instructs in activity modification, use of ice post-exercise
- Virtual check-in lasts 10 min; bill one unit G2012CRGO

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Example: Telehealth

- 47 yo patient s/p R ACL reconstruction; elects to receive telehealth OP PT treatments via Zoom for Healthcare
- PT observes AROM R knee, patient demonstrates exercises he was taught in the clinic; PT gives verbal instructions/ demonstration for 2 new closed chain exercises.
- PT asks patient to amb w/ and w/o cane, observing phases of gait, deviations, deficits, etc. and cueing/instructing as appropriate.
- PT instructs patient to continue with HEP 2-3x/day, work on normalizing gait pattern.
- Session lasts for 26 min; bill one unit 97110GP95 (16 min) and one unit 97116GP95 (10 min)

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Practice Considerations

- Confirm eligibility – both to provide and to bill for telehealth/virtual care
- Ensure consent requirements are followed
- Establish P&P re: contingency plans if issues with platform, internet connectivity, patient complications/emergency during intervention, etc.
- Check with malpractice insurance carrier
- Determine primary needs re: technology/IT and ensure appropriate location/surroundings from which to conduct telehealth/virtual care

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Resources

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Resources

- AOTA COVID resources: https://www.aota.org/Practice/Health-Wellness/COVID19.aspx
- AOTA Advocacy: https://www.aota.org/Advocacy-Policy.aspx
- AOTA telehealth resources: https://www.aota.org/Practice/Manage/telehealth.aspx
- AOTA webinar series: https://www.aota.org/Conference-Events/Coronavirus-COVID19.aspx

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Resources

- APTA. Telehealth Resources http://www.apta.org/Telehealth/
- APTA. Telehealth Modalities http://www.apta.org/Telehealth/COVID-19/Modalities/
- CMS Coronavirus Waivers & Flexibilities https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers
- CMS Fact Sheet – Telemedicine (3/17/20) https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- CMS Interim Final Rule (3/20/20) https://www.cms.gov/files/document/covid-final-ifc.pdf
- Center for Connected Health Policy https://www.cchpca.org/
- HHS. HIPAA, Civil Rights, and COVID-19: Notice of Discretion for Telehealth https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

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Resources

- CMS Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf
- NARA COVID-19 Resources https://www.naranet.org/resources/covid-19-resources

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