HCCI in collaboration with West Health Institute and Northwell presents

Navigating COVID-19 Challenges with Telehealth

Q) How do you decide which patients to visit at home F2F vs tele-visit?

A: One thing that we didn't mention about Northwell is that it is in downstate NY, which has been hit the hardest by the COVID pandemic. We have converted most of the practice into the telehealth delivery practice, and we are only seeing patients face to face (F2F) using proper PPE when that F2F visit is going to change clinical management. It has been difficult on our staff as we love making house calls, and everyone is chomping at the bit as to when it will be safe to go back into the home. In the future iterations of this telehealth, once the pandemic has declined a little bit, we are going to be using it as an adjunct to our F2F visits. In some cases, we have very long drive times between patients, and we are evaluating skin rashes. Telehealth would be a perfect tool to assist with this type of visit. We will start shaping the uses of telehealth to a clinical need, but as of now we are doing about 95%+ of our visits by telehealth.

Q) When you are conducting a family meeting and the patient is not involved, can you use 99358?

A: CPT 99358 is for prolonged services non-face-to-face (F2F). In order to bill CPT 99358, all the time spent must be directly related to a F2F or a telehealth visit if you were talking to the responsible family member for a follow-up discussion, which was directly related to the telehealth visit then potentially yes. CPT 99358 is a time-based service which requires a minimum of 31 minutes to be spent on the non-F2F work. Please be advised that Chronic Care Management and CPT 99358 are bundled and cannot be reported within the same calendar month. Your documentation must clearly support the total time spent, start and stop times for the service, and the nature and/or description of how the time was spent or what was discussed with the family. You need to clearly link or document which F2F or telehealth encounter it relates to, and I encourage you to be as specific to support medical necessity.

I included a link to a past HCCI Practice Management Tip of the Month, which outlines the requirements for CPT 99358.

Q) What checklists are available for providers and family care givers to help improve experience, and assure that important information is covered?

A: Part of the reason that we set up the visit in the beginning with the patient and the caregiver to say that this is going to be similar to how we would do a regular F2F visit is so that the provider can also mentally prepare going through all the regular steps. Using the EMR helps as a cheat sheet to ensure reviewing med reconciliation, the review of systems, and all the components that would be done in a F2F visit. We do not give the patient any kind of checklist because we don't want it to be on the patient to have to remember or navigate various components of the telehealth visit. As the provider, the person doing the visit, need to make them feel comfortable, that we are following the flow of a regular visit so that we do not leave anything out. And of course, at the end, asking if there are any questions or anything, we need to address before ending the visit is important.

Q) Are there any special considerations when doing telehealth visits for patients with Alz/Dem diagnoses?

A: It is much different doing a telehealth visit for a patient who has advanced dementia versus someone who can participate in the video visit themselves. Often a lot of the F2F time on the visit is done with the caregiver, that is just like a regular Housecall that you might be doing with those patients that are not verbal/unable to communicate, and it is just as important that we make the family and the caregiver feel comfortable with the telehealth component of the visit. It can be a little more awkward because the caregiver does need to bring the iPad or the phone over to the patient and actually really facilitate the physical exam by moving the camera as the patient is unable to do so him or herself. It is more challenging, and it doesn't feel as personal with the patient as it does with someone who is able to participate. We can certainly get a lot of the physical exam done and provide that reassurance to the family or the caregiver that we are still there to help when they need it.

Q) For the virtual check ins and e-visits how are we billing since they are already technology-based codes? POS 02? Or same as telehealth with POS 11 and modifier 95?

A: Virtual Check-ins, E-visits, and remote patient monitoring are not included on Medicare's list of telehealth services. Therefore, since these technology services are not considered telehealth by CMS, you would report the POS where the service was rendered (e.g., POS 11), and no telehealth modifier is needed. CMS is currently not using the POS 02, so these would be reported like other non-face-to-face services.

Q) What are some good platforms, I would like some information on how to construct a telehealth policy?

A: Sharing a little about the journey that Northwell took we investigated software and platforms. One of the things that our executive team decided was important was that there was a variety of ways to connect using the platforms. We did not want our providers or patients to be locked into computers, we wanted something that was flexible. Our security bar is quite high, and that was obviously a hurdle that many of our vendors needed to meet in a significant way. Think about what your patients need, explore the different platforms, have the flexibility to be on the computer, phone, or tablet as this can be helpful for those who are unaware of wireless internet in their homes. From a thought of how to construct a telehealth policy, the avenue that Northwell took was to really structure it as using telehealth to provide to provide clinical care rather than a care delivery model in its own right. So, adding an addendum to the clinical care policy to include telehealth as a virtual visit was how we approached making the policy for our clinical care providers. It was also very security based so we knew our patient's information would be safe both during the visit as well as after the visit.

Q) As the president for Geriatric Medicine Pas, it would be great to hear additional pearls for technology troubleshooting with the geriatric population. Even general observations are welcome. (Ex.: iPads better tolerated for the patient than smaller smartphone?) Thank you for considering this topic.

A: There are pluses and minuses to using iPads versus smart phones. One of the things was that a patient trying to connect through the iPad and an email had to be sent. The patient wasn't getting the email and we ended up having to connect through the smartphone with an invite via text message. In our practice we have found that anything that can be sent via text message – and that is true for doximity as well – is the easiest to use for patients and caregivers. Also, smart phones and tablets are much more advantageous for patients with limited mobility as the device itself can be moved. A patient that is bed bound could not be able to open the camera on their computer and easily participate in the visit; anything that is mobile is much better.

Q) CPT E/M codes 99347-99350 can be bill using just phone services? Or is it really needed 2-way video and audio?

A: Two-way audio and video technology that permits real-time communication between the provider and patient is required for all of the home and domiciliary E/M codes. The majority of Medicare telehealth services still require a video component, including CPT 99347-99350. The only exception where Medicare will pay for certain audio-only services is telephone E/M, virtual check-ins, advance care planning, and other care management services. You can review the Medicare list of telehealth services, which has a column that indicates which certain services can be paid for using audio-only.

During the PHE, the U.S. Department of Health and Human Services (HHS), the Office of Civil Rights (OCR) Notification of Enforcement Discretion relaxed HIPAA requirements so that providers may use platforms such as Apple FaceTime, Facebook Messenger video

chat, Google Hangouts video, Zoom, or Skype, etc., as acceptable forms of two-way audio and video telecommunications. (e.g. Free HIPAA Compliant platform: Doxy.me). No public-facing applications, *e.g.,* Facebook Live, Twitch, TikTok, may be used.

Q) Are there specialists using your telehealth platform in the care of these patients? (psychiatry/psychologist for example)?

A: I think everywhere it is going to be different. In downstate NY, there is a huge variety of practices that have switched to telehealth because of how hard we have been hit here. There is really an explosion in terms of adoption of telehealth models. Perhaps places that are not as hard hit will not have as much. For those patients who are homebound and unable to see a specialist, the telehealth visits have allowed them to see those specialists and has really been a benefit to them.