Telemedicine Policy and Procedures

Revised: March 23, 2020

I. PURPOSE:

To ensure appropriate utilization of Telemedicine services during the COVID-19 National Public Health Emergency.

II. POLICY:

All providers and staff will adhere to the recommended guidelines from CMS and HHS regarding Telehealth services.

Effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare (and several other of the major insurers) will make payment for Medicare telehealth services furnished to patients in broader circumstances.

Telehealth services are paid under the Physician Fee Schedule at the same amount as in-person services. The patient must verbally consent to receive virtual check-in services, and this must be documented in the chart note. This is not limited to only rural settings. There are no geographic or location restrictions for these visits.

The provider must use an interactive audio and video telecommunications system that permits real- time communication between the distant site and the patient at home. Distant site practitioners who can furnish and get payment for covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals. These visits are considered the same as in-person visits and are paid at the same rate as regular, in- person visits.

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.

III. Visit Descriptions and Billing during the COVID-19 Public Health Emergency

A. "Telehealth Visit"
   a. We must have documented verbal permission from the patient agreeing to have a telehealth visit vs. a visit in the office
   b. This visit requires audio and visual capabilities
   c. This visit is considered the same as in-person visit and is agreed upon by the patient in lieu of an in-person visit.
   d. For new and established patients
   e. Billed using normal level of E&M visit codes (see Onco how-to-document)

B. "Virtual Check-in" – COMING SOON
   a. A brief communication with a patient via telephone or other telecommunication modality, such as audio/video, secure text messaging, or email.
   b. For established patients only
   c. Communication should not be related to a medical visit within the previous 7 days and does not lead to a medical visit within 24 hours.
   d. The patient must verbally consent to receive a virtual check-in
   e. Billed using HCPCS codes

Type of Service	What is the Service	HCPCS/CPT Code	Patient Relationship to Provider
Telehealth Visits	A visit with a provider that uses telecommunication with both audio and video between a provider and a	Common telehealth services code include: 99201-99215 For a complete list go to: https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-	New or Established Patients

	patient	codes	
Virtual Check-ins	A brief (5-10) minute 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	Established Patients

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IV. PROCEDURES:

i. A HIPAA compliant device should be utilized
   a. One-touch Telehealth is the preferred method for telemedicine at Mission Cancer + Blood

ii. Non-HIPPA compliant but still allowed for this crisis: Skype or Facetime or any technology enabling a video and audio connection with the patient.

V. PATIENTS SCHEDULED WITHIN 1 WEEK

i. Mission providers will review their patient lists to determine patient eligibility for telemedicine based on patient acuity and care needs.

ii. Physician/Nursing teams will call patients to determine telehealth capabilities following the provided script and asking the following questions:
   a. Does patient want to change scheduled visit to a telemedicine visit?
   b. Does patient have a smart phone or computer with video chat capabilities?

c. Ask patient if they have any concerns or questions.

iii. If patient agrees to telemedicine visit

a. MISSION providers will utilize "MD Follow Up Telehealth Visit or MD New Patient Telehealth Visit" activity in OncoEMR
b. MISSION providers will utilize "MD Follow Up Visit Telehealth Note or MD Initial Consult Visit Telehealth Note" for visit documentation
c. MISSION providers will document in Telemedicine Visit Note that patient agrees to telemedicine visit. Under the Assessment/Plan tab of the note in the Discussion section check the box called Telehealth Informed Consent and a statement will be auto populated.
d. MISSION providers will utilize OneTouch Telehealth or other alternative video to meet with patient

VI. PATIENTS THAT DECLINE TELEMEDICINE:

i. Patients that decline telemedicine will be offered the option to reschedule their visit during a "safe clinic" on the weekend.

FAQs

ii. What did CMS do to remove limitations on telehealth?

a. Under the waiver, limitations on where Medicare patients are eligible for telehealth will be removed during the emergency. In particular, patients outside of rural areas, and patients in their homes will be eligible for telehealth services, effective for services starting March 6, 2020. Current telehealth law only allows Medicare to pay practitioners for services like routine visits furnished through telehealth under certain circumstances. For example, the beneficiary receiving those services must generally be located in a rural area and in a medical facility. Where the beneficiary receives those services is known as the "eligible originating site." The beneficiary's home is generally not an eligible originating site, but under the new 1135 waiver, this will be waived during the emergency. This will now allow telehealth services to be provided in all settings – including at a patient's home.

iii. What services can be provided by telehealth under the new emergency declaration?

a. CMS maintains a list of services that are normally furnished in-person that may be furnished via Medicare telehealth.
b. This list is available here: https://www.cms.gov/Medicare/Medicare-GeneralInformation/Telehealth/Telehealth-Codes.
c. They include the following commonly used codes:

99201	Office/outpatient visit new
99202	Office/outpatient visit new
99203	Office/outpatient visit new
99204	Office/outpatient visit new
99205	Office/outpatient visit new
99211	Office/outpatient visit est
99212	Office/outpatient visit est
99213	Office/outpatient visit est
99214	Office/outpatient visit est
99215	Office/outpatient visit est
99231	Subsequent hospital care
99232	Subsequent hospital care
99233	Subsequent hospital care

iv. Would physicians and other Qualified Providers be able to furnish Medicare telehealth services to beneficiaries in their homes?

a. Yes. 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.

v. Who are the Qualified Providers who are permitted to furnish these telehealth services under the new law?

a. Qualified providers who are permitted to furnish Medicare telehealth services during the Public Health Emergency include physicians and certain non-physician practitioners such as nurse practitioners, physician assistants and certified nurse midwives. Other practitioners, such as certified nurse anesthetists, licensed clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals may also furnish services within their scope of practice and consistent with Medicare benefit rules that apply to all services. This is not changed by the waiver.

vi. Will CMS enforce an established relationship requirement?

a. No. It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

vii. Is any specialized equipment needed to furnish Medicare telehealth services under the new law?

   a. Currently, CMS allows for use of telecommunications technology that have audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication they qualify as acceptable technology. 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.

viii. How does a qualified provider bill for telehealth services?

   a. Medicare telehealth services are generally billed as if the service had been furnished in-person. For Medicare telehealth services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional telehealth service from a distant site.

ix. How much does Medicare pay for telehealth services?

   a. Medicare pays the same amount for telehealth services as it would if the service were furnished in person. For services that have different rates in the office versus the facility (the site of service payment differential), Medicare uses the facility payment rate when services are furnished via telehealth.

x. How much does Medicare pay for telehealth services?

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xi. How long does the telehealth waiver last?

   a. The telehealth waiver will be effective until the PHE declared by the Secretary of HHS on January 31, 2020 ends.

xii. Should on-site visits conducted via video or through a window in the clinic suite be reported as telehealth services?

   a. Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same

location as the beneficiary.