ACG Practice Management Toolbox
Essential Guide to Telemedicine in Clinical Practice: EASY STEPS TO RAPID DEPLOYMENT

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INTRODUCTION
In this toolbox article, we outline a five-step plan for gastroenterology practices to transition rapidly and successfully to telehealth during the novel coronavirus disease (COVID-19) crisis while recognizing important clinical, technology, legal, regulatory, and reimbursement aspects of this service. It is important to recognize that telehealth requirements during this public health crisis are significantly broader than before this crisis, and will likely change significantly when the national emergency period ends.

TOPIC OVERVIEW
Despite COVID-19, our patients still have gastrointestinal (GI) conditions including inflammatory bowel disease, cirrhosis, chronic pancreatitis, eosinophilic esophagitis, and others which require ongoing and careful treatment. Faced with concerns about exposure to this virus, there has never been a better time to harness the strengths of telemedicine. By adapting to changing times, gastroenterology practices can leverage telemedicine to maintain patient access to GI healthcare through this crisis. Telehealth supports "social distancing" efforts and eliminates patients' travel costs, missed time from work, and childcare barriers to care. Recognizing that natural history of all pandemics, telehealth is strategic toward ensuring financial practice viability and maintaining employment for highly-skilled staff during a severe economic crisis. To ensure that patients can still receive the best possible care, regulatory agencies, and insurers are temporarily reducing barriers to telehealth, which we will outline in this article. Practices should continue to pay close attention to evolving requirements and nuanced differences among Medicare, Medicaid, and commercial insurers, and also stay up-to-date with state regulations and licensing requirements for telehealth as this crisis evolves.

GETTING STARTED: COMMON LICENSURE AND MALPRACTICE QUESTIONS

Where can I access detailed information on telehealth policy in all 50 states?
The following website has detailed information listed by state and by insurance type. Importantly, there is also information on parity laws detailing in which states private payers are required to reimburse for telehealth services. In light of the pandemic, however, this information will be constantly evolving.

Resources
COVID-19 related state actions

Telehealth in your state prior to COVID-19

Does my medical license allow me to practice telehealth?
In most states, no special licensing is required beyond your existing professional medical license.

Does my malpractice policy cover telehealth?
This is determined by your individual coverage policy. Some carriers already include coverage, while others may require an additional rider or premium. It is strongly encouraged to review covered services with your malpractice carrier to ensure your practice and you are covered fully.

Resources
- Federation of State Medical Boards (FSMB) Statement on Supporting States in Verifying Licenses for Physicians Responding to COVID-19 Virus (March 13, 2020)

STEP 1 – DEVELOP A PRACTICE POLICY ABOUT TELEHEALTH

Patients at risk for death or serious complications from COVID-19 should be prioritized for telehealth
- Age > 65
- Chronic health problems
- Patients with acute gastrointestinal symptoms (nausea, diarrhea, abdominal pain) often preceding the respiratory illness. These patients often lack a history of GI illness.

Resources
- Pan L, Mu M, Ren HG, et al. Clinical characteristics of COVID-19 patients with digestive symptoms in Hubei, China: a descriptive, cross-sectional, multicenter study. *American Journal of Gastroenterology.* Accepted. Click here to read.

Can I schedule Medicare, Medicaid, and commercially insured patients using telehealth?
- New and established Medicare patients can use telehealth under the current national emergency (this includes all patients, not just services to help diagnosis/treat COVID-19)
- At least 41 states and the District of Columbia have parity laws in place requiring commercial insurers to reimburse for telehealth
- More states are allowing new and established Medicaid patients to be scheduled using telehealth under the current national emergency
- To encourage "social distancing," several states are allowing real-time audio-only to replace videoconferencing requirements for telehealth visits.
- It is important to stay up-to-date on this rapidly evolving area.

My practice's catchment area includes multiple states. What if the patient is physically located in another state? Am I allowed to see my patients who live in another state without a license in that state?
It is very important to review information relevant to your state and payer mix in this rapidly evolving area. From an insurance standpoint, CMS has temporarily waived requirements for Medicare that out-of-state providers be licensed in the state where patients are physically present. Many state Medicaid programs and commercial insurance plans are following suit. The Interstate Medical Licensure Compact already expedites state licensing to practice telemedicine in several states. Several state medical boards are allowing out-of-state physicians to continue to care for their patients who reside out-of-state.

What if I encounter licensing or insurance barriers to seeing out-of-state telehealth patients in my catchment area?

If commercial payers do not allow reimbursement for in-state licencsed providers to care for out-of-state patients, or if out-of-state licensing boards do not allow you to continue caring for your out-of-state patients in your catchment area, or if you are unsure:

(1) Check the latest requirements in your state [here from the Center for Connected Health Policy](#).

(2) Contact your state's ACG Governor, the corresponding state licensing board, or state medical association for advice to learn about ongoing work to address licensing and coverage barriers to appropriate medical care during this crisis.

(3) Contact your state Governor's office so that they can ensure that you maintain the ability to meet the clinical needs of patients in your catchment area during this health crisis (reference: ACG Practice Management Toolbox: [Advocacy and Resources for Effective Political Action in Gastroenterology](#).

STEP 2 – BUILD A SCHEDULING PROCESS

How do I build a telehealth schedule?

Most integrated electronic health record (EHR) platforms already offer the ability to accurately capture telehealth charges. Work with your practice manager to build a new "place-of-service" to enable telehealth, and pay attention to billing code modifiers described later in this document.

How do I transition my scheduling grid to telehealth?

Start your telehealth program at the end-of-day, with longer visits, and with gaps between patients to accommodate technology issues. You can also consider opening up a session on a weekend or after hours when you have more time. "Start small". Expect some technology hiccups—both for you and your patients—as you rapidly learn how to use a new healthcare delivery platform.

What types of visits should I build into the schedule?

In designing your telehealth schedule, realize that telehealth use the E/M codes you already know, but their use is billed on time, not on E/M service, because of the lack of a physical exam.

1) Schedule **telehealth visits** using real-time videoconferencing technology to replace new and established patient office/outpatient appointments.

2) Schedule extended **telephone calls** in lieu of telehealth visits for patients who lack sufficient technical knowledge or equipment to allow real-time videoconferencing. **Note, however that a recent ACG pilot study utilizing the ACG specific telehealth platform, GI OnDEMAND, found that most patients regardless of age were comfortable using the platform.** Note that several mechanisms may be useful for charge capture of a telephone call; an increasing number of states are allowing telehealth visit codes to be applied to audio-only phone calls for both new and established patients.

3) Block off time for **e-visits** to answer patient questions on your patient portal to avoid unnecessary visits.

How do I convince my patients move to telehealth instead of cancelling their appointment?
Consider scripting videoconferencing telehealth as a default option for your scheduling secretaries and **encourage your patients that they will still receive outstanding care**, rather than offering several choices among videoconferencing, a phone call, or cancelling outright.

There is a national shortage of videoconferencing cameras which many of my patients don't have.
Screen for hardware during the scheduling process. Recognize that some platforms will allow patients to access telemedicine services by smartphone and tablet, which can minimize barriers to entry. For patients who lack the necessary hardware, schedule phone calls. Alternatively, you as the physician can consider switching to audio-only if needed during a telehealth visit for patients who encounter difficulty setting up. States are increasingly allowing real-time audio-only telehealth using telehealth visit codes during this crisis, but this area remains rapidly evolving and highly variable.

My patients will probably have difficulty installing and testing the software. How can I help them?
The most important step is to send clear and concise instructions through the patient portal so that patients can install and test the technology on their own before their visit. You can also consider assigning a tech-savvy scheduling secretary or assistant to help patients with difficulties and to identify patients who truly need audio-only telehealth. Some telehealth options (for example, doxy.me) are fully web-based and require no downloading or installing at all; patients using these options just log-in on a website, and many patients have found that much simpler.

Do patients have to consent to using telehealth?
Best practices recommend that patients consent to using telehealth services, so it is important to consider this as a part of your scheduling workflow. State laws and licensing boards govern this process: some states do not require consent at all, while others require a signed consent form for the initial telehealth visit (which can often be signed electronically, but not always). Ensure that your practice manager helps you to review and build the legally required consent process (electronic signature, paper signature, or provider documentation only) into your scheduling workflow.

Click here for example telehealth consent forms

How do I create a process to schedule patients for telehealth?
  1) ***Identify*** – Assign staff to identify priority patients for telehealth according to your practice policy.
  2) ***Educate*** – Assign staff to contact identified patients, discuss telehealth using a script, and ensure they have the technology they will need to complete the telehealth visit (smartphone or computer with camera, patient-side software based on your chosen telehealth platform).
  3) ***Convert*** – Change patients from in-person to the appropriate telehealth visit type (telehealth visit, telephone call, in-person, or cancel).
  4) ***Visit*** – See the patient!

Are telehealth requirements different among Medicare, Medicaid, and commercial insurance plans?
YES. The "telehealth visit," which serves as a replacement for the office consultation, is the most commonly covered visit type and should be the primary focus of your efforts. While covered by Medicare and Medicaid, it is important to stay up-to-date with coverage policies for your individual commercial payer mix (as well as telehealth coverage requirements enacted by state action) as this crisis evolves.

Are there other types of telemedicine to cover audio-only phone calls and portal messages?
First, consider whether your state temporarily allows you to conduct real-time audio-only telehealth visits (using the same E/M codes as a full in-person office visit).

Otherwise, Medicare has two prime options: "e-visits" and "virtual check-ins." These mechanisms are intended for physicians and advanced practice providers to help patients avoid unnecessary follow-up visits. In addition, Medicare has long offered a "prolonged non-face-to-face encounter" mechanism which exists outside of telehealth. Coverage for these mechanisms is variable outside of Medicare, but we include them here as payer coverage (or dictates on coverage enacted by state action) evolves with this crisis.

It is important for you and your practice manager to consider (1) your local Medicaid and commercial payer policies and (2) your state's requirements for telehealth coverage by commercial insurance, as you consider how to leverage these several options to meet your patients' needs.

Table: Mechanisms for your practice manager to consider as you build your telehealth program

	MECHANISM OF CARE *(Insurance considerations in italics)*	INTENDED USE	ELIGIBLE PROVIDER TYPES	COMMUNICATION MEDIUM
Consultation visits	**Telehealth visit** *Broader coverage*	Replaces the office/outpatient visit Covers new* and established patients	Physicians, advanced practice providers, clinical psychologists, clinical social workers, registered dietitians, nutrition professionals	Real-time videoconferencing (some states including California are allowing real-time audio-only phone calls during this crisis)
Blocked time for provider to answer the patient portal	**E-visit** *Likely Medicare-specific*	Responding to established patients on a patient portal	Providers who are eligible to bill using E/M codes (physicians, advanced practice providers)	Patient portal
Scheduled telephone visits and unscheduled phone calls responding to patients	**Virtual check-in** *Likely Medicare-specific*	Answering questions from patients who initiate contact with the provider	Providers who are eligible to bill using E/M codes (physicians, advanced practice providers)	Telephone or other audio, video, secure text messaging applications, or patient portal <u>Real-time communication not required</u>
	Prolonged non-face-to-face care *Possibly broader coverage*	Communicating with established patients OR Communicating with new patients with an upcoming scheduled appointment OR Conducting other non face-to-face work between visits without patient communication	Providers who are eligible to bill using E/M codes (physicians, advanced practice providers)	ANY! In fact, this mechanism does <u>not</u> even require any communication with patients and should NOT be built as a telehealth appointment. This mechanism also does <u>not</u> require a specific place-of-service.

* "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." (Reference: https://www.cms.gov/newsroom/fact-sheets/medicare-telehealth-health-care-provider-fact-sheet)

Resources

[Top Five Things Gastroenterologists Should Know About Telehealth](#)

[About virtual check-ins](#)

[About e-visits](#)

[Medicare Telemedicine Health Care Provider Fact Sheet](#)

STEP 3 – CHOOSE A TELEHEALTH PLATFORM TO REACH YOUR PATIENTS

Several important factors drive practice choices among various telehealth platforms. Does your EHR already allow you to do these things, or do you need more functionality? If your EHR already provides most of these tools, then a simpler platform may be best.

- HIPAA-compliant (<u>required</u> outside of the current national emergency)
- Appointment reminders
- Scheduling capabilities
- E-prescribing
- Billing support
- Single- or multi-provider support
- Messaging capabilities
- Access or use of online forms (virtual check-ins, consents for example)
- Revenue cycle management
- Real-time video conferencing ability

GI practices are successfully transitioning using one of the three products below:

Name	Information	Cost	Link
GI OnDEMAND*	• An ACG-endorsed member benefit • HIPAA compliant • Includes secure video, and end-to-end practice management tools like scheduling, document sharing, EHR integration, and billing, can be used by providers and patients on computers, laptops, tablets, and smartphones • Dedicated to practice of gastroenterology	Waived subscription fee, $1 per session fee only. No threshold of use limits.	https://giondemand.com/
Doxy.me	• HIPAA compliant • Includes secure video • Patient consent (being added)	Free, or subscription model	https://doxy.me/
FaceTime, Skype with your own EHR (such as Epic)	• NOT HIPAA-complaint, however the Office for Civil Rights will "exercise enforcement discretion and waive penalties" for providers acting in good faith during public health emergencies*	Free	

*GI OnDEMAND is a joint venture between American College of Gastroenterology and Gastro Girl, Inc.**Reference: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

STEP 4 – HOW TO DOCUMENT TELEHEALTH ENCOUNTERS DURING VISITS

Visit type	Documentation pearls
Telehealth visit	• Requires the same documentation as an office visit absent the physical examination or vital signs • Requires a time-based billing statement with a stated time for counseling and coordination-of-care exceeding at least 50% of the total visit time • Can be done in most EMR/EHR platforms *Examples:* 1) *New consultation for dyspepsia and diarrhea* 2) *Follow-up visit for Crohn's disease*
Virtual check-in (i.e. a telephone call mechanism)	• Requires that "the patient provides verbal consent to receive virtual check-in services" *Examples:* 1) *Returning a phone call to a patient to update the care plan.* 2) *Writing back to the patient with your interpretation of a drug rash, based on a picture of a rash sent by the patient to you over the portal.*
E-visits	• Requires that "the patient provides verbal consent to receive e-visit services" *Example: Responding to several messages back and forth with a patient spanning three days.*

Prolonged non-face-to-face services (i.e. a telephone call mechanism)	• Start and end times for this overall service should be documented and need not be continuous, but all billed time must occur within the same calendar day
	• Documentation and a brief summary of eligible activities which were provided (i.e. chart review, coordination of care, calling a patient and/or provider, and documentation and summarization of the care plan in a note)
	• You must attest to the total time spent on this service (which must be at least 31 minutes)
	• You must reference the scheduled date of a prior or upcoming office or telehealth visit
	• Review specific documentation requirements with your practice manager
	Examples:
	1) *Calling a patient to update the care plan after extensive testing.*
	2) *Calling a patient to discuss care in detail to avoid an unnecessary in-office visit.*
	3) *Performing extended chart review on the patient.*
	4) *Documenting an updated care plan for the patient.*
	5) *Speaking with colleagues in other specialties about the patient.*

STEP 5 – CHARGE CAPTURE

Many of my patients are financially devastated. Are regular co-pays and deductibles waived for my patients during the COVID-19 crisis?
CMS is allowing practices to waive co-pays and deductibles for Medicare patients during this national emergency. Several commercial insurers and state Medicaid programs are following suit, but this is a rapidly evolving area that you should continue to monitor. These co-pays and deductibles may likely return after the current national emergency ends.

Resource
OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak. Click here to read.

What was telemedicine like before the COVID-19 crisis?
Medicare only covered telehealth under limited circumstances: when the person receiving the service is in a designated rural area and when they leave their home and go to a clinic, hospital, or certain other types of medical facilities for the service. Several Medicaid programs and commercial insurance had variable coverage or no coverage for telemedicine. It is likely that many of these changes will revert once the current national emergency ends, so it is important for you and your practice manager to stay up-to-date with telemedicine licensing rules and payer coverage policies through this crisis.

What changed after the COVID-19 crisis started?
"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."

Resource

Medicare Telemedicine Health Care Provider Fact Sheet

Telehealth visits
Uses office-based codes billed on face-to-face time (of which a documented number of minutes exceeding 50% of total time must be spent on counseling and coordination of care) as follows:

New patient office/outpatient visit			Office consultation (new patient)			Established patient office/outpatient visit		
Code	Time requirement	wRVU	Code	Time requirement	wRVU	Code	Time requirement	wRVU
99203	30-44 minutes	1.42	99243	40-59 minutes	N/A	99213	15-24 minutes	0.97
99204	45-59 minutes	2.43	99244	60-79 minutes	N/A	99214	25-39 minutes	1.50
99205	60 minutes	3.17	99245	80 minutes	N/A	99215	40 minutes	2.11

Reference: 2020 Centers for Medicare & Medicaid Services Physician Fee Schedule

Virtual check-in
This service should not be billed if it occurs
within seven days following a visit and is covered by Medicare Part B. Appropriate codes are listed below but may not be recognized by all payers.

Code	Description
HCPCS code G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
HCPCS code G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.

Reference: CMS Fact Sheet.

E-visits
Physicians, nurse practitioners, and physician assistants can use 99421 (5-10 minutes), 99422 (11-20 minutes), and 99423 (21 or more minutes) to capture the total time spent by the provider over a seven-day period over the patient portal to answer a patient-initiated message for Medicare Part B enrollees. Appropriate codes are listed below but may not be recognized by all payers.

Non face-to-face prolonged care
Physicians, nurse practitioners, and physician assistants can use 99358 (first 31 to 74 minutes), add-on code 99359 (for 75 to 104 minutes total time), second add-on code 99359 (for 105-134 minutes total time) for Medicare Part B enrollees but these codes might not be recognized by all payers. It is important to recognize that these codes exist outside the spectrum of the telehealth place-of-service, are already covered by Medicare for you to use in your practice as part of prolonged non-face-to-face care, and have not changed during this national emergency as of this writing. More information on these codes can be found here:

Resource
Christopher Y. Kim, Braden Kuo, Glenn D. Littenberg. 2017 Coding Updates. Gastroenterology CPT Advisors. Click here to read.

SUMMARY: IMPORTANT DETAILS FOR YOUR PRACTICE MANAGERS

- Consultation codes are not recognized by Medicare, but can be billed to some commercial insurers. These are generally automatically downcoded to "new patient office" codes when not recognized.
- Place of service (POS) "02 – Telehealth" must be on the claim for Medicare. Some commercial insurers may require a different POS (such as 11) so that they recognize the visit in their existing system.
- Modifier GQ (asynchronous telecommunications system) is required if the provider is affiliated with a federal telemedicine demonstration in Alaska or Hawaii.
- Modifier 95 indicates "Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System" and is relevant to telehealth visits meeting this criterion but should not be used for virtual check-in, e-visit, or a prolonged non-face-to-face encounter. Use this modifier for commercial insurance claims. At this time, this modifier is optional for Medicare. (please note the difference between the POC code and a modifier)
- These codes cannot be billed on E/M services and must be billed on time, as a physical examination cannot be performed.
- The facility fee cannot be billed, unless the patient is physically located at the referring physician's office (which is not recommended during the COVID-19 crisis).

Resources

Top Five Things Gastroenterologists Should Know About Telehealth

American College of Physicians Telehealth Coding Tips

American Medical Association (AMA) Quick Guide to Telemedicine in Practice

AMA: Special telehealth coding advice during COVID-19 public health emergency