TELEMEDICINE AND COVID-19 IMPLEMENTATION GUIDE

AMERICAN ACADEMY OF NEUROLOGY®

The AAN developed this guidance for clinicians and practices looking to implement telemedicine services amid the COVID-19 crisis. Regulations discussed below have effective dates of March 6, 2020[1], for the duration of the Public Health Emergency as determined by the Department of Health and Human Services (HHS). Because of the unique nature of a Public Health Emergency, some guidance may not align with the AAN's overall Telemedicine Position, which was created in and intended for non-emergency periods.

If your institution or practice has existing telemedicine programs, we encourage you to communicate with your compliance, coding, and IS teams to understand internal telemedicine policies and procedures.

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[1] As determined by CMS. Other payers and states may have a different starting date.

SETTING UP TELEMEDICINE

HIPAA Compliance

While HHS will waive potential HIPAA penalties for good faith use of telemedicine during the Public Health Emergency, including the use of FaceTime and Skype, consider choosing a platform that is HIPAA compliant to avoid complications after the emergency has ended.

Technology

The AAN does not endorse any one vendor over another. Below are several vendors with which AAN members have had success.

- Zoom: *https://zoom.us/healthcare*
- Doxy.me: *https://doxy.me/*
- Vidyo: *https://www.vidyo.com/video-conferencing-solutions/industry/telemedicine*

Some telemedicine platforms integrate into EHRs, usually in the form of starting a new encounter. However, this is not needed to perform a telemedicine visit and may add steps to your documentation workflow. The Texas Medical Society has compiled a list of additional telemedicine vendor options, which includes features and pricing information; the AAN cannot guarantee the accuracy or timeliness of the list.

State Licensure and Regulations

Typically, you must be licensed in the state where the patient is being seen. However, under most recent changes, this restriction has been lifted. If you are licensed in ANY US state, you can see the patient in any location.

States have additional regulations pertaining to telemedicine visits. To ensure compliance, visit these resources:

- Center for Connected Health Policy
- eVisit

Malpractice Insurance

Notify your malpractice carrier about this new modality of care. Some states and carriers require completion of specific forms.

BEFORE THE EXAM

Existing Patient Relationship

CMS

HHS will not conduct audits to ensure that an established relationship existed for claims submitted during the Public Health Emergency. However, having an established relationship can aid in the success of the visit.

Private payers

Some private payers are following CMS' guidance during the Public Health Emergency. You should always check with the specific payer to see if there are any limitations on coverage. America's Health Insurance Plans (AHIP) is tracking many private payers' changes, but this may not be an all-inclusive list. It is important to check the patient's plan to ensure they have coverage for telemedicine services.

Patient's Originating Site

CMS

CMS is waiving the originating site requirement during the Public Health Emergency. Medicare will pay for telemedicine services regardless of where the patient is located, including in their homes.

Private Payers

Some private payers are following CMS' guidance during the Public Health Emergency. You should always check with the specific payer to see if there are any limitations on coverage. AHIP is tracking many private payers' changes, but this may not be an all-inclusive list. It is important to check the patient's plan to ensure they have coverage for telemedicine services.

Insurance and Co-pays

CMS

The use of telemedicine does not change the out-of-pocket costs for beneficiaries with Original Medicare. Beneficiaries are liable for their deductible and coinsurance. The HHS Office of Inspector General (OIG) is providing flexibility for health care providers to reduce or waive cost-sharing for telemedicine visits paid by federal health care programs.

Private Payers

Some private payers are waiving co-pays and cost-sharing. It is important to review the payer's website or speak with provider services with the payer. AHIP is tracking many private payers' changes, but this may not be an all-inclusive list. It is important to check the patient's plan to ensure they have coverage for telemedicine service.

NEUROLOGIC EXAM

Initial Salutation

Telemedicine services must be patient-initiated, and because Medicare coinsurance and deductibles apply, the patient must give verbal consent to these services.

Use a two-factor identifier, such as patient's name and date of birth, before starting the visit to avoid misidentification.

Follow appropriate tele-bedside manner recommendations.

Consent

It is required to obtain consent from the patient in order to conduct a remote visit, and it is best practice to obtain the consent on every remote visit. Standard language may be integrated into your EHR and may include:

This is a telemedicine visit that was performed with the originating site at [INSERT PATIENT LOCATION] and the distant site at [INSERT PROVIDER LOCATION]. Verbal consent to participate in video visit was obtained. This visit occurred during the Coronavirus (COVID-19) Public Health Emergency. I discussed with the patient the nature of our telemedicine visits, that:

- **I would evaluate the patient and recommend diagnostics and treatments based on my assessment**
- **Our sessions are not being recorded and that personal health information is protected**
- **Our team would provide follow up care in person if/when the patient needs it**

The American Telemedicine Association has additional sample consent forms.

Tips on Performing the Neurologic Exam

- **Mental status:** While often easy to ascertain, some patients have visual, auditory, and/or cognitive deficits, making the exam more of an observational exercise
- **Speech:** Start by evaluating comprehension (midline commands, appendicular commands, cross midline commands), then naming, repetition
- **Cranial Nerves:**
  - Visual Fields: May be able to evaluate on the screen or with the help of someone with the patient
  - EOM: Can use the assistance of someone with the patient
    - Ask patient to look all the way to the left, right, up, and down
    - Can have patient fixate on camera and rotate head from side to side for fixation
    - Comment on nystagmus if present
  - Pupils: Some platforms offer zooming options that you can use to examine pupils
  - Face: Examine visually by video
  - Hearing: Able to evaluate grossly and can document that it is intact to voice
  - Palate: Some platforms offer zooming options that you can use to examine palate
  - Shoulders: Check shoulder shrug symmetry
  - Tongue: Examine visually by video
- **Motor exam:** Tremors can be easily seen on camera
  - Strength: Can be examined via nonconfrontational measures by:
    - Arms: using pronator/Digit Quinti sign/Barrel roll/finger taps for subtle signs of weakness
    - Legs: check drift or ask the patient to stand up with arms crossed, crouch then stand, heel walk, plantar walk (when possible)
    - Using the assistance of someone with the patient; For complex peripheral cases you can instruct the assistant how to examine the different roots, branches of the brachial and lumbar plexus and individual nerves
  - Tone: may be difficult to examine, but can look for bradykinesia by inspection
- **Sensory exam:** Need help of someone with the patient
  - May ask for difference between left/right/different dermatomes if examiner is skilled
  - May check for extinction with double stimulation by instructing examiner how to do it
- **Cerebellar:** Ideal to have the help of someone with the patient, or finger to nose or heel, knee, shin test
  - Can ask the patient to extend arm all the way out, then touch their own nose
  - Can instruct heel to shin easily
  - Gait testing helps with looking for ataxia
- **Reflexes:** May be difficult to examine without a skilled examiner, but can instruct someone with the patient how to look for the Babinski response

PRESCRIBING MEDICATIONS

Prescribe medications as you normally would. For the duration of the Public Health Emergency, DEA-registered practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, provided all of the following conditions are met:

- The prescription is issued for a legitimate medical purpose by a practitioner acting in the usual course of his/her professional practice
- The telemedicine communication is conducted using an audio-visual, real-time, two-way interactive communication system
- The practitioner is acting in accordance with applicable federal and state law

CODING THE VISIT

Determine which code set most appropriately captures the service you are providing based on available technology and nature of the encounter (e.g., telephone only, or patient setting). There are both Current Procedural Terminology (CPT) codes and G-codes* that represent telemedicine services.

Coding TIP: G-codes can be reported for Medicare patients and some carriers, whereas CPT codes can be reported for all patients. Code selection is based on payer coverage and institutional coding rules. We recommend consulting with your coding or compliance department to determine which code is most appropriate for you.

Access a full list of CPT and G-codes codes with descriptors here.

DEFINITION

**In addition to the CPT codes, the Centers for Medicare and Medicaid Services (CMS) occasionally creates their own codes known as a G-code, which serves the same purpose as the CPT code, but is Medicare-specific. Medicare will create a G-code if there is a service that has not been assigned a CPT code, or if CMS wants to modify an existing CPT code for a variety of reasons. Some commercial carriers accept G-codes instead of a corresponding CPT code.*

Online Digital E/M

99421, 99422, 99423

Three code levels to select from depending on duration of encounter. 99421–99423 can only be reported for an **established patient** and may only be reported once in a seven-day period. If the patient had an E/M service within the past seven days, 99421–99423 may not be reported for the same problem.

99421–99423 do not require video and can be asynchronous.

Telephone Consultation Codes

99441, 99442, 99443

Three code levels to select from depending on duration of call. This is a good option if video software or equipment is not available. The initial call must be initiated by the patient and the provider must return the call. 99441–99443 cannot be reported for calls placed by nurse or other clinical staff conveying the physician's recommendation. If the call results in an office visit within 24 hours, the telephone service cannot be billed. 99441–99443 cannot be billed if there is a telemedicine visit within the past seven days for the same problem.

Virtual Check-in

G2012

G2012 is analogous to 99441. This must be a patient-initiated service and because Medicare coinsurance and deductibles apply, the patient must give verbal consent to these services. The same rules apply regarding timing of the call, in relation to prior or future office visits, as those rules for 99441–99443.

Inpatient E/M

G0406, G0407, G0408, G0425, G0426, G0427, G0508
This service is reported for consultations provided via telemedicine provided when the patient is in the inpatient setting.

95 Modifier: E/M codes that may be reported for synchronous telemedicine services

99201–99205, 99212–99215, 99231–99233
Modifier 95 indicates *"Telemedicine Service Rendered via Real-Time Interactive Audio and Video Telecommunications System."*

These E/M codes may be used for reporting synchronous (real-time) telemedicine services when appended by modifier 95. These services involve electronic communication using interactive telecommunications equipment that includes, at a minimum, audio and video.

LIMITATIONS OF THE TELEMEDICINE EXAM

Generally, if you are unable to perform an exam with 100-percent certainty, then you should recognize this as a limitation of telemedicine practice and document as such. Best practices include avoiding "guessing" over telemedicine. You can document that, based on your exam, the patient appears to have [XYZ] findings but this is a limited evaluation by telemedicine evaluation. A telemedicine exam is primarily focused on the history and what you can observe.

Based on consensus, without specialized equipment or the aid of a trusted telepresenter, items that are not to be evaluated with a telemedicine exam include:

- A comprehensive eye exam (fundoscopy)
- Neuromuscular components (reflexes, tone, cogwheeling, strength grading)
- Vestibular (any provoking maneuvers that require head movement when using a fixed camera)