Takeaways from MHA Webinar:

Emergency Department Telemedicine Reimbursement COVID-19 Update
May 12, 2020

Overview

The COVID-19 crisis has forced hospitals to create new ways to deliver patient care, especially in the ED. The burgeoning telemedicine industry has expanded significantly as hospitals and physicians have used telemedicine to carry out social distancing and increase access to care. Government and private regulations have been rewritten completely to support this expansion. Attend this webinar and listen to Michael Granovsky, President of LogixHealth, and Elijah Berg, CEO of LogixHealth, discuss the latest telemedicine adaptations in the ED and understand how to ensure compliant reimbursement and best practices to ensure your hospital’s success and survival.

Need to Know

**COVID Related ED Visits.** In terms of national volume data, there has been a maximum decrease in the emergency department of 50% nationwide from the January, 2020 baseline levels. The volume is slowly improving and has improved by 8% since this baseline. In the month of April, 25-35% of nationwide ED visits were COVID related and since late April/early may, COVID visits as a percentage are trending downwards. In terms of May 2020 acuity, surge RVU per patient increased 20% compared to the pre-COVID January 2020 baseline. It is also important to note that patients seem to be delaying or avoiding ED care, as it’s been observed that there have been large drops of ED visits for various conditions including chest pain, pharyngitis, appendicitis, stroke and others.

**Telemedicine Acute Care Reimbursement Update.**

**General Post-COVID Telemedicine Waivers:** Limitations that have been waived include patient geographic limitations, patient location limitations, and existing patient relationship requirements. Additionally, technology standards have been relaxed.

**CMS-1744-IFC Big ED Telemedicine Changes:** There are 4 big changes that have taken place in the reporting of telemedicine services. (1) Telehealth services have been expanded to include ED and observations, specifically CPT codes 99281-99285. (2) ED Telehealth should use ED specific POS #23 rather than POS#2. (3) Modifier 95 should be applied to claim lines that describe services furnished vie telehealth. (4) Telemedicine is paid at the same rate as in person services.
**Telemedicine Provider Documentation Process:** Providers should document in the same manner as face-to-face visits and practice similar medical decision making such as differential (including COVID concern, any prescriptions, testing or self-monitoring instructions.

**Office Telehealth Hx and PE Requirements Waived:** CMS had already waived Hx and PE requirements for office/urgent care codes (99201-99215) starting on January 21, 2021. This is being accelerated. Telehealth, for the office codes, during the Public Health Emergency, can be based on MDM or time rather than History and Physical Exam.

**Teaching Physician Oversight Via Telehealth:** Teaching physicians may now meet the supervisory requirements to bill using telehealth and does not need to be in person.

**EMTALA:** Under EMTALA, emergency physicians and other health care practitioners are able to conduct medical screen exams via telehealth. Emergency Physicians can perform medical screening exams outside of the ED in places such as tents. Lastly, the use of telehealth to provide evaluation of individuals who have not physically presented to the hospital for treatment does NOT create an EMTALA obligation.

**Swab Only (No Provider Evaluation: Medicare Reporting):** CMS has created a new code to report facility component of COVID-19 testing. HCPCS code C9803 (hospital outpatient clinic visit specimen collection for sars-cov-2)