

TELEMEDICINE AND COVID-19 IMPLEMENTATION GUIDE



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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 1, 2020¹, 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

Several states are offering expedited licensure or waiving it all together. Despite CMS reimbursing for care provided to Medicare beneficiaries without requirements for licensure where that patient is, states retain their sovereign rights to regulate the practice of medicine within its boundaries. Please refer to the [FSMB list of states'](#) waivers or expedited licensure.

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

While having an established relationship can aid in the success of the visit, it is not a requirement for a telemedicine visit for the duration of the public health emergency.

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

Ensure that the patient (and if relevant, the family, caregiver, and/or interpreter) is present, in a well-lit location, and somewhere they are able to speak freely.

Use two-factors to verify the patient's identity, 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. The consent does not need to be written or signed by the patient.

If your institution or practice has existing telemedicine programs, we encourage you to communicate with your compliance and other internal teams regarding established consent policies, which may include documenting who is present during the visit and the patient's consent to their presence.

Standard language may be integrated into your EHR. The American Telemedicine Association has [sample consent forms](#). Here is one example:

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**

Tips on Performing the Adult Neurologic Exam

- **General appearance:** By inspection via video
- **Vital signs:** The patient can use home equipment, if available, to check blood pressure, pulse and weight
- **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: The assistance of someone with the patient may be helpful
 - Ask patient to look all the way to the left, right, up, and down
 - 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, if not ask the patient to hold the camera close to their eyes 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 with appropriate lighting. An onsite assistant may be helpful
 - Shoulders: Check shoulder shrug symmetry
 - Tongue: Examine visually by video
- **Motor exam:** May need help of someone with the patient for detailed assessment
 - 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, toe 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
 - Tremors can be easily seen on camera
- **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:** May need help of someone with the patient
 - Ask the patient to extend arm all the way out, then touch their own nose (finger to nose maneuver)
 - Can instruct heel to shin easily
 - Gait and station testing assists in testing 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

Tips on Performing the Pediatric and Adult with Intellectual Disabilities Neurologic Exam

This section's guidance was developed in collaboration with the Child Neurology Foundation and the Child Neurology Society.

Consider doing the exam first because being at home, the patient's attention can wander, or they may fall asleep before the exam is started.

- **Vitals:** Document the intent to do vitals in note. Patient can be weighed by caregiver during video visit (note source of weight; usually ask for at the beginning of the meeting). Wearable and home devices with data can be documented.
- **General Appearance/Skin:** Observe how the patient looks and acts. If needed, have the caregiver undress the patient to allow visualization of potential neurocutaneous skin lesions. Be aware of potential signs and symptoms of neglect or abuse. Poor cooperation and/or room lighting may affect the reliability of observations.
- **Mental status:** Perform a developmentally appropriate exam as you would perform in the office. It may be more difficult to engage younger children with video.
- **Language and Speech:** Listen for speech and ask the patient to speak, if able. When possible, engage the patient in a conversation. This can also help assess affect. Proceed to orientation, fund of knowledge, attention, naming, and recall/memory.
- **Cranial Nerves:**
 - EOM: Can use the assistance of someone with the patient or by observation of activities in background
 - Consider using toys or objects patients prefer and have the patient look all the way to the left, right, up, and down
 - Can have patient fixate on camera and have caregiver 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: observe if patient responds to noise in background or speaks after you speak to them
 - Palate: Prioritize if needed; some platforms offer zooming options that you can use with appropriate lighting
 - Shoulders: Check shoulder shrug symmetry, if possible, or observe as the patient turns from side-to-side
 - Tongue: Examine visually by video
 - Evaluate patient sucking and swallowing to assess bulbar function

- **Motor exam:** May need help of someone with the patient for detailed assessment
 - Strength: Can be examined via nonconfrontational measures by:
 - Arms: using pronator/Digit Quinti sign/Barrel roll/finger taps for subtle signs of weakness. Have them perform a push-up and/or plank (with younger children, instruct family how to use wheelbarrow position).
 - 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
 - Tone: difficult to assess remotely
 - Tremors can be easily seen on camera
- **Sensory exam:** Not likely helpful for pediatric patients and not reliable for caregiver to do
- **Cerebellar:** Ideal to have the help of someone with the patient
 - Can ask the patient to extend arm all the way out, then touch their own nose or grab object from caregiver or rapid, alternating hand sequences
 - Can instruct heel to shin, if able
 - Gait and station testing assists in testing for ataxia; ask patient to walk. Can attempt to observe heel and toe walking as well as tandem walking
- **Reflexes:** May be difficult to examine without a skilled examiner, but can instruct someone with the patient how to look for the plantar response; for younger infants, use Moro

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

A [summary of CMS benefits](#) as it relates to telehealth coverage for Medicare beneficiaries was published on March 30, 2020, which expanded coverage even further. The modifications made for Medicare beneficiaries may not apply to those covered by Medicaid or commercial payers.

The codes outlined below are frequently reported for telemedicine services. Review the full list of [Medicare covered telehealth services](#) here.

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.

Until new CMS guidance during the current public health emergency, only codes listed in Appendix P of the CPT manual could be performed virtually. There were also G-codes for virtual encounters. They are not listed in Appendix P since they are not CPT codes. Now many additional E/M services can be performed virtually. Modifier requirements can vary among payers, so it is important review your coverage policies prior to submission.

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.

DEFINITION

**In addition to the CPT codes, the Centers for Medicare and Medicaid Services (CMS) occasionally creates their own codes known as a G-codes, which serve 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.*

Place of Service

For Medicare claims

When billing professional claims for non-traditional telehealth services with dates of services on or after March 1, 2020, and for the duration of the public health emergency use the Place of Service (POS) code that would have been reported had the service been furnished in person along with a modifier 95, indicating that the service rendered was actually performed via telehealth. For example, a physician practicing in an office setting who sees patients via telehealth would report POS 11 (Office).

In ordinary circumstances providers use POS 02 (Telehealth) code to indicate the billed service was furnished as a professional telehealth service from a distant site. During the public health emergency, CMS recognizes that physician practices are transitioning a potentially significant portion of their services from in-person to telehealth visits during the COVID-19 pandemic, yet still incurring resource costs just as they would if services were still furnished in person.

CMS states that practices may continue to use POS 02 should [they] choose, for whatever reason," but will be paid using the lower facility payment rate."

For commercial payer claims

We encourage members to review their payers' websites for coding-related guidance specific to telehealth services during COVID-19 as POS guidance may vary.

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 for cumulative time during that 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. For the duration of the public health emergency G2012 can be used for new or established patients. The same rules apply regarding timing of the call, in relation to prior or future office visits, as those rules for 99441–99443.

G2010

G2010 is reported for the remote evaluation of recorded video and/or images submitted by a new or established patient. Typically, the practitioner looks at the image or video and subsequent communication by the practitioner or other clinical staff with the patient takes place. Follow-up with the patient in an at least 5-minute response is required, which can be in the form of a telephone discussion, audio-video communication, secure text message, email, or patient portal communication. 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, 99221, 99222, 99223, 99232, 99233

This service is reported for consultations provided via telemedicine provided when the patient is in the inpatient setting.

GT Modifier

GT can be appended to any CPT code for services that were provided via telemedicine. It is most often used for codes such as 99201-05 or 99211-15.

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

99201–99205, 99212–99215, 99231–99233, 99238, 99239

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. Modifier 95 is similar to GT in use cases, however prior to the crisis was limited in the codes it could be appended to. Modifier requirements vary and should be reviewed with payers prior to submission.

LIMITATIONS OF THE TELEMEDICINE EXAM

Generally, if you don’t think you can make an accurate diagnosis or treatment plan based on the virtual exam, 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, detailed assessment of tone, and strength)
- Vestibular (any provoking maneuvers that require head movement when using a fixed camera)