Dear NANS members,

We are hope you and your family are doing well during this time of global crisis. Together we can beat this horrible disease and we urge you to remain strong and stick together in this fight. America is resilient and we will persevere, we will all have plenty of stories to tell our grandchildren someday. We are sure many of you have made the switch to Telemedicine for your patient visits already and we would urge you to do that with as many patients as possible to limit traffic flow through your office.

The goal should be to limit exposure to your patients for your staff and yourself. That means as few patients/people coming through the office as possible; basically, pump refills, someone you just have to examine face-to-face, and a patient who needs an injection, so they don't have to go the Emergency Room with pain. Family members and/or friends should wait in the waiting room or even better in the car-you can call the driver when the patient is ready for pick up. Avoid having children in the exam rooms if possible (they touch everything). Visits from vendors should also be suspended at this time. You must assume everyone has Covid-19, even if they don't know it and are not showing any signs, remember upwards of 80% of those people infected appear to be basically asymptomatic.

Err on the side of caution, if a patient has potentially been exposed to someone with a fever, consider conversion to Telemedicine and cancelation of any procedure you may have planned. You may want to consider moving pump refill dates up sooner so that you have more leeway with refill date in case of a patient reported febrile illness. If you are injecting steroids, you should warn the patient of the potential for increased risk of complications related to a Covid-19 infection. If you proceed, consider lowering the dosage.

With this correspondence we will provide you some useful information on Telemedicine, its requirements, and billing and coding information. This is rapidly changing, and it is likely rules will be updated frequently as problems are identified. NANS will do its best to keep you abreast of other major changes. Attached are also samples of office notifications to post on your door and office safety protocols for your staff. These are not fixed, and you may want to adjust ages or aspects of these to make them more or less strict for your practice, they are merely samples. Your ability to keep operating will be your ability to keep yourself and your staff disease free.

Under the 1135 waiver authority and coronavirus preparedness and response supplemental appropriation act, the Centers for Medicare and Medicaid Services (CMS) increased access to Medicare telehealth. Based on this waiver, Medicare can now pay for office, hospital, and other visits furnished via telehealth. Prior to the waiver, telehealth was only paid on a limited basis. Multiple types of virtual services exist including telehealth visits, virtual check ins and E-visits. While Medicare requires live video (you and the patient need to be able to see each other live) while performing a Telemedicine visit many carriers are waiving this requirement and some states have ordered private carriers to waive this requirement (that still would not apply to Medicare).

Medicare has said it will not pursue HIPPA violations related to the use of Telemedicine during this time of crisis. Therefore, you can use other forms of video communication including FaceTime and Skype. It is possible they will relax the rules requiring live video as well, especially since so many seniors have trouble with this activity. As these are the most vulnerable population CMS will want these patients to stay at home.

Rather than repeat official policy, we have provided you with direct links to CMS and AMA advice on Telemedicine. In one attachment, we have provided some general advice as to what we have learned about different private carriers but we warn you this may or may not apply to your locale and we advise strongly that each state check this information out with their local private carriers. As you learn what each of your carriers are doing, please disseminate that amongst your colleagues within your state, we

are all in this together. WC will vary state to state and you will need to contact your WC commission to ask how Telemedicine is being handled, at this point it is our understanding that most are covering at this time.

Most carriers (including Medicare) are allowing evaluations of both existing patients (99211-99215) as well as new patients (99201-99205) via Telemedicine. If you do the visit by live video, you bill the normal EM code as if its in the office. Medicare and most major carriers have said they will reimburse this at 100% of the normal visit. I would also note that some carriers have said they will waive patient co-pays for these Telemedicine visits. If the visit is purely telephonic then there is a different set of codes (99441-3). Site of service for most carriers (including Medicare) is -02 but a few private carriers have different coding requirements.

Some carriers have specific codes which they want you to use and so your billing team will unfortunately need to check with each of your carriers to confirm the proper code that they want. Medicare requires no modifier, many carriers want a -95 modifier, and still other carriers have asked for a different modifier; again we have provided some general guidance from the major carriers but given that different areas have different administrators you should check with your local plan to make sure this is what they want (it may vary somewhat on the computer system the local carrier is using). I urge each of you to share that information with other physicians in your state as you learn what each carrier wants for coding; we are all in this together.

The requirements for documentation are the same as if you did the service and billed that code in the office. Clinical documentation that follows the 1995/1997 CMS documentation guideline definition of the three key components of an E/M visit (patient history, patient examination, and complexity of medical decision making) is required to justify a specific code. We suggest that in most instances you will be achieving your coding level by your documentation and not time so please carefully document your visit with the patient (you certainly have the time now). For example, a level three (99213) established patient office visit can be billed if you spend 15-25 minutes with the patient and/or family member or documentation establishing at least two of the following three components of medical decision making (an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity) for a presenting problem of low to moderate complexity. Lower level visits like a 99212 require less time (10-15 minutes) and/or a low complexity presenting problem, and higher level visits like a 99214 require more time (25-40 minutes) and/or a higher level of complexity presenting problem. Include time spent counselling regarding Covid-19 infections which you should be doing with all patients, it is amazing how many are still naïve as to how serious this really is.

As for the best Telemedicine system, NANS does not endorse any one company and there are multiple excellent choices. Most are already HIPPA compliant (and the government has said they will not enforce HIPPA on Telemed visits anyway). In the case of elderly patients and others who may not have access to a computer or be able to figure out the computer link, you can try Facetime if they have a smart phone. Your goal should be to do as many as you can by live video. Once you settle on a system, create specific step by step instructions, preferably with screen shots that you can email the patients, it will significantly increase the number who can do this online with you. You will inevitably have to do a few purely telephonically.

We have been asked by many doctors as to guidance on what are appropriate and what are not appropriate procedures at this time. This is a national crisis and medical supplies are in short order, we must all do our part to help conserve resources. Elective surgery should certainly be postponed as this uses up valuable PPE (personal protective equipment) supplies and this would include stimulator trials (SCS, DRG, and PNS), stimulator implants (SCS, DRG, and PNS) and new intrathecal pumps; a pump reaching EOL may or may not be elective depending on the medications being infused. If you can safely

wean and convert to orals this may be in the best interest of both the patient and yourself, the hospitals will be very high risk for Covid 19 exposure as the numbers of infected people continues to grow all over the country in the next 3-5 weeks. Patients with an acute radiculopathy should avoid surgery at this time and so they may require injections at this time to keep them from going to the ER with severe pain. Consider lowering your steroid dosage in at risk populations (if not everyone). Other procedures and the 'essential' nature must be decided on a local level based on the individual facts in the case. Keeping patients functional during this crisis is also important as many have essential jobs they must perform. Be smart and ethical about what you are doing, conserve supplies where you can (you may not be able to replenish some of your office supplies like gloves for a while). We all must do our part during this crisis.

Please do not hesitate to reach out to NANS and its leadership at this critical time, we are here to help you, we are all in this together. Feel free to reach out to us directly or via the following address: info@neuromodulation.org

Sincerely,

David Kloth, MD and David Provenzano, MD

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