Telemedicine After the COVID-19 Pandemic: Where Do We Go From Here?

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History of Telemedicine

- **1905**: William Einthoven transfers electrocardiograms electronically.
- **1960**: First used by NASA to monitor health of astronauts in space.
- **1972**: Murphy and Bird conduct 500 patient consultations via "interactive television".
- **1990**: Telemedicine matures; widespread acceptance of teleradiology practices.
- **Today**: Internet & smartphone use and PHE.

10/18/2021
Consumer Adoption of Telemedicine

46% of US consumers April 2020

11% of US consumers 2019

Specialists whose practices are using telemedicine the least to interact with patients are:

- Allergists/immunologists—6.1 percent.
- Gastroenterologists—7.9 percent.
- Ob-gyns—9.3 percent.
Physician Adoption of Telemedicine

Providers are seeing 50 to 175 times the number of patients via telehealth than they did Pre-COVID-19 pandemic.

Almost half of doctors are using telehealth to treat patients as the COVID-19 pandemic changes practice patterns and care delivery.


Virtual Visits may potentially account for $250 billion, or 20%, of what Medicare, Medicaid and commercial insurers spend on outpatient, office and home health.

2020 State of Telemedicine Report Examining Patient Perspectives and Physician Adoption of Telemedicine Since the COVID-19 Pandemic Sept 2020 doximity

Public Health Emergency

March 13, 2020- National Emergency declared by President Trump
July 23, 2020- U.S. Department of Health and Human Services (HHS) renewed the COVID-19 public health emergency (PHE) declaration
Oct 23, 2020- U.S. Department of Health and Human Services (HHS) renewed the COVID-19 public health emergency (PHE) declaration
Jan 1, 2021- Renewal of Determination That A Public Health Emergency Exists by Secretary of Health and Human Services
January 22, 2021- Health and Human Services (HHS) Acting Secretary Norris Cochran sent a letter to governors announcing that, "the [Public Health Emergency (PHE)] will likely remain in place for the entirety of 2021, and when a decision is made to terminate the declaration or let it expire, HHS will provide states with 60 days' notice prior to termination."
July 20, 2021, HHS Secretary Xavier Becerra extended the National Public Health Emergency (PHE) for an additional 90 days, meaning that telehealth and other waivers and flexibilities that have been implemented will remain in place until October 20, 2021.
HHS Secretary Becerra is expected to extend the National PHE order until at least December 2021.
Proposed Medicare Physician Fee Schedule would extend most telehealth waivers until December 2023.

PHE status = continued waivers and expansions for telehealth
Recommended Utilization of Telemedicine During COVID-19

• Screen patients who may have symptoms of COVID-19 and refer as needed
• Provide low-risk urgent care for non-COVID-19 conditions and refer as needed
• PCP and specialists, including mental health, for chronic health conditions and medication management
• Provide coaching and support for patients managing chronic health conditions (weight, nutrition)
• Physical therapy, occupational therapy, as a hybrid approach to in-person care


Recommended Utilization of Telemedicine During COVID-19

• Case management for patients who are difficulty accessing care (e.g., rural settings)
• Monitor chronic conditions (blood pressure, blood glucose)
• Hospital follow-up
• Advance care planning to patients and caregivers to document preferences if a life-threatening event or medical crisis occurs
• Non-emergent care to residents in long-term care facilities
• Education and training for HCP through peer-to-peer professional medical consultations (inpatient or outpatient) that are not locally available


But we have used telemedicine for even more...
Number of telehealth patient encounters reported by four telehealth providers that offer services in all states and percentage change in telehealth encounters and emergency department (ED) visits — United States, January 1–March 30, 2019 (comparison period) and January 1–March 28, 2020 (early pandemic period)*


57% of providers view telehealth more favorably than they did pre-COVID-19

64% of providers are more comfortable using telemedicine

76% of consumers indicated likely use of telehealth post-pandemic

Half of people age 35-49 prefer combo of in-person and telemed care

Most common desire for use of telemed: ask medical questions, review lab results, get prescription refills

51% of providers view telehealth more favorably than they did pre-COVID-19

 alf of providers are more comfortable using telemedicine

-Mckinsey covid19 consumer survey, Apr 2020

-Harris Poll, May 2020
• 88% of patients rated their comfort level seeing a doctor via telemedicine as a 10/10
• 40% rated their virtual visit equivalent or superior to a traditional outpatient encounter

Harvard University and Phreesia, a healthcare software company, analyzed data from 50,000 Phreesia clients. They found that overall visits to ambulatory practices are still 10% below baseline numbers from the week of March 1, 2020.

Possible underestimation due to not capturing non-scheduled telephone encounters

June 2020

Teledmedicine use among health care provider organizations.
Challenges

Why the decline?

In the McKinsey survey, three-quarters of participants were interested in virtual visits, but <50% of those interviewed were utilizing telehealth applications.

- Lack of knowledge of what illnesses can be seen via virtual visits
- Lack of knowledge of insurance coverage
Challenges

Why the decline?

• Technical difficulties
• Time commitment: staff and patient training
• Workflow integration
• Effectiveness of in person vs virtual visits
• PHI security
• Question of future reimbursements
• Decreasing COVID-19 numbers

• Disappointed with the limitations of the physical examination
• Decreased access to ancillary testing such as laboratories and pulmonary function tests
• Discomfort with video conferencing technology
• Compromise to the level of rapport with the doctor
What we have learned?

- Telemedicine use was lower in areas with higher poverty rates (31.9% vs 27.9% for the lowest and highest quartiles of poverty rate).
- In rural counties, there was a lower proportion of care performed through telemedicine than in urban counties (23.9% vs 30.7%).
- The use of telemedicine varied by specialty, with 68% of visits being with an endocrinologist and 9% being with ophthalmologists.
- Other specialties that did not see large spikes of telemedicine visits included optometry (3.3%), physical therapy (6.6%) and orthopedic surgeons (20.7%).
- Mental health reasons such as depression (53% of visits), bipolar disorder (55%), and anxiety (53.9%), all resulted in increased telemedicine visits, while 3% of visits were for glaucoma.
- Higher usage rates for common conditions were associated with smaller decreases in total weekly visits.

Harvard investigators, including Ateev Mehrotra, a member of the Managed Healthcare Executive® editorial advisory board,

Where do we go from here?

64% of patients

Would change providers if:
- no ensuring safety
- can’t access their health data
- can’t see their doctor via telehealth

Where do we go from here?

- Patient satisfaction
- Waivers
- Effectiveness of in person vs virtual visits
- Types of patients and diagnosis
- Question of future reimbursements
Where do we go from here?

Patients and providers like telemedicine

10-20% of total visits?

Where do we go from here?

• Patient satisfaction
• Waivers
• Effectiveness of in person vs virtual visits
• Types of patients and diagnosis
• Question of future reimbursements
Waivers allowing telemedicine to grow

1. HIPAA flexibility
2. Medicare and Medicaid policies
3. Licensure requirements
4. Prescribing controlled substances

What allowed telehealth to grow

1. HIPAA flexibility
HHS Office for civil rights temporarily decided to "exercise enforcement discretion; waive penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communication technologies such as facetime or skype." There is no video requirement for telephone visit, only audio.

### COVID-19: Unmasking Telemedicine

**TABLE 1.** Examples of encrypted telemedicine platforms during the COVID-19 pandemic

<table>
<thead>
<tr>
<th>Platform</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doximity</td>
<td><a href="https://www.doximity.com/">https://www.doximity.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Kinsa</td>
<td><a href="https://www.kinsa.com/">https://www.kinsa.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Medb</td>
<td><a href="https://www.medboxfamily.com/">https://www.medboxfamily.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Poly Health</td>
<td><a href="https://www.polyhealth.com/">https://www.polyhealth.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Zoom</td>
<td><a href="https://zoom.us/">https://zoom.us/</a> (accessed May 9, 2020)</td>
</tr>
</tbody>
</table>

**TABLE 2.** Examples of non-encrypted telemedicine platforms during the COVID-19 pandemic

<table>
<thead>
<tr>
<th>Platform</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Google Hangouts</td>
<td><a href="https://hangouts.google.com/">https://hangouts.google.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Skype</td>
<td><a href="https://www.skype.com/">https://www.skype.com/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Zoom</td>
<td><a href="https://zoom.us/">https://zoom.us/</a> (accessed May 9, 2020)</td>
</tr>
<tr>
<td>Zoom—Free and regular paid versions</td>
<td><a href="https://zoom.us/">https://zoom.us/</a> (accessed May 9, 2020)</td>
</tr>
</tbody>
</table>
What allowed telehealth to grow

2. Medicare and Medicaid policies: The Centers for Medicare & Medicaid Services has instituted several changes that directly affect reimbursement for telehealth, including the following:

• Recognizing a patient’s home as an originating site
• Expanding eligibility to all Medicare recipients, not just those who live in rural areas
• Allowing telehealth visits for new patients, in addition to established patients
• Expanding recognized provider types, such as physical therapists
• Recognizing Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) as the distant (provider) site in a telehealth encounter
• Allowing audio-only telehealth

What allowed telehealth to grow

3. Licensure requirements:
Multiple states allowed temporary licenses to physicians licensed in other states to increase access to care via telehealth during the pandemic.
What allowed telehealth to grow

4. Prescribing controlled substances:
Prescribers allowed to prescribe controlled substances to patients regardless of location

Where do we go from here?

• Patient satisfaction
• Waivers
• Effectiveness of in person vs virtual visits
• Types of patients and diagnosis
• Question of future reimbursements
Where do we go from here?

- Patient satisfaction
- Waivers
- Effectiveness of in person vs virtual visits
- Types of patients and diagnosis
- Question of future reimbursements
What type of patients

After the pandemic...

New vs Established

Certain appointment types not suitable for telemedicine
  - Procedures need to be performed
  - Risk to the patient
What type of patients

After the pandemic...

Certain appointment types that can be done easily via telemedicine
- Chronic urticaria
- Immunotherapy follow up
- Stable asthma when not due for spirometry
- Immunology
- Covid vaccine questions including history of reactions
- Post discharge monitoring
- School based clinics
- Multidisciplinary clinics
- Prison based clinics
- Nursing home based clinics

What type of patients

After the pandemic...

Certain appointment types that can be done easily via telemedicine
- Medication refills, review of medications
- Review labs
- Counseling of diet-food allergy, elimination
- Education
- New therapy check in
- Follow-up sick visits
- Urgent sick visit
The Use of Telemedicine for Penicillin Allergy Skin Testing

Mary L. Staicu, PharmD, Anne Marie Holly, RPA-C, Kelly M. Conn, PhD, and Allison Ravosey, MD
Rochester, NY

What is already known about this topic? Penicillin skin testing is increasingly used as a tool to evaluate penicillin allergy in patients with a reported history, given the significant clinical and financial consequences associated with the penicillin allergy label.

What does this article add to our knowledge? This is the first report that assesses and describes the use of real-time, interactive video conferencing or telemedicine to facilitate inpatient penicillin skin testing.

How does this study impact current management guidelines? This novel approach optimizes allergy/immunology resources with a high degree of patient satisfaction. The minimal technology and trained personnel required has the potential to enhance patient access to allergy services while optimizing available resources.

- JACI in Practice, online access May 2018
- 46 PST-negative patients, 33 were transitioned to a B-lactam
- $30,000 was saved throughout the study period.

Where do we go from here?

• Patient satisfaction
• Waivers
• Effectiveness of in person vs virtual visits
• Types of patients and diagnosis
• Question of future reimbursements
Legislation

Protecting Access to Post-Covid-19 Telehealth Act of 2021-reintroduced 1/2021

1st introduced July 2020-stalled
• Eliminate most geographic and originating site restrictions
• Authorize Centers for Medicare and Medicaid Service to continue reimbursement for telehealth 90d beyond PHE
• Make permanent the disaster waiver authority
• Require a study on use of telehealth during covid (costs, health outcomes, racial, geographic disparities)

Legislation

• State Legislation
  • NJ
    • addresses reimbursement parity
    • prevent health plans from imposing restrictions of location telehealth provided
    • Bill 523 join interstate Medical Licensure Compact
  
  • Delaware
    • Passed legislation July 2020- use of visual communication not required
    • Originating site can be outside DE as long as DE resident
CTeL is a 501(c)3 nonprofit, political and vendor-agnostic research institute

• Focus on laws, policies and regulations impacting the delivery of virtual care
• Has met the research needs of stakeholders and government entities - including the White House, HHS and Congress for 25 yrs
• Committed to making high-quality, accessible virtual care for all through data and research backed policy initiatives

CTeL produces two kinds of research:

• State and Federal Policy Analysis
• Data-Driven Cost Impact Research
CTeL’s Telehealth Cost Impact Study

• Scheduled to be released in the Fall of 2021
• Includes data from more than 1.5 million telehealth encounters from March 2020 to September 2020
• CTeL has collected data from Medicare Part A, Medicare Part B, Medicare Advantage, Medicaid, commercial insurers, and self-pay encounters
• CTeL’s study will give policymakers a thorough analysis of telehealth access, utilization, services provided, and cost.

Findings

• CTeL’s initial findings show that expanded telehealth is cost-saving or cost-neutral to the federal government, depending on service area
• A significant portion of the telehealth services provided during the Public Health Emergency were for treating mental and behavioral health conditions
• No evidence that telehealth is inherently more fraudulent than in-person care.
Where will Legislation go from here?

- CTeL optimistic that Congress and the Administration will likely make some telehealth waivers permanent, while continuing to extend certain flexibilities until they can receive additional data and evidence
- There has been a lot of bipartisan support, both at the state and federal levels, for expanding access to mental and behavioral health telehealth services
- The telehealth community should continue to engage with their state departments of health and plan for the eventual end of telehealth flexibilities.

Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Telemedicine Association COVID-19 resources</td>
<td><a href="https://www.americalined.org/covid-19-resources">https://www.americalined.org/covid-19-resources</a></td>
</tr>
<tr>
<td>ACOG guidelines to support telemedicine as an effective tool for allergy</td>
<td><a href="https://www.acog.org/guidelines-support_telemedicine_efficient_tool_for_allergy">https://www.acog.org/guidelines-support_telemedicine_efficient_tool_for_allergy</a></td>
</tr>
<tr>
<td>ACOG COVID-19 and allergy, asthma and immune deficiency patients</td>
<td><a href="https://www.acog.org/articles/2019/03/19/asthma-and-allergy-and-immune-deficiency-patients-3-12-20">https://www.acog.org/articles/2019/03/19/asthma-and-allergy-and-immune-deficiency-patients-3-12-20</a></td>
</tr>
<tr>
<td>AAAI telemedicine training resources</td>
<td><a href="https://www.aai.org/articles/2020/06/26/telemedicine-training-resources-2020-06-26">https://www.aai.org/articles/2020/06/26/telemedicine-training-resources-2020-06-26</a></td>
</tr>
<tr>
<td>Medicine, Prevention, and Health</td>
<td><a href="https://www.medicalnewstoday.com/articles/1001450">https://www.medicalnewstoday.com/articles/1001450</a></td>
</tr>
<tr>
<td>Medicine, Medical frequently asked questions</td>
<td><a href="https://www.vamc.med.va.gov/medication-guide/frequently-asked-questions-faq.html">https://www.vamc.med.va.gov/medication-guide/frequently-asked-questions-faq.html</a></td>
</tr>
</tbody>
</table>

Key Points

Telemedicine is here more than it ever has been and we are at the precipice; more studies in our field
Lucky to have the ability to still be able to connect with our patients during a global pandemic
The pandemic has taught us that there is a place for telemedicine in a traditional allergy practice as an additive service (10-20%?)

Thank you!

Jennifer.a.shih@emory.edu
Telemedicine and Digital Health Post-COVID: Where Do We Go From Here?

Tania Elliott, MD FAAAAI FACAAI

Objectives

1. Recognize the Continued Value of Virtual Care
2. Understand the Changing Telemedicine Regulatory Landscape
3. Review Optimized Workflows for Virtual Care Implementation
4. Discuss Opportunities with Remote Patient Monitoring
5. “Where do we go from here?” Overview
The Continued Value of Virtual Care

Virtual care’s inflection point...

July 2019 - March 1, 2020

~16,500 virtual visits

March 1, 2020 - August 18, 2021

>2,580,000 virtual visits

Source: Ascension claims data
Virtual Care: Myths vs. Reality

Myth 1: Virtual care is limited to video and telephone visits
There are many virtual solutions that support care beyond video and telephone visits.

<table>
<thead>
<tr>
<th>Communication technology based services</th>
<th>Synchronous video</th>
<th>Patient surveillance</th>
<th>Connected devices</th>
<th>Facility patient monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Image/video upload e-consults</td>
<td>Virtual Provider Office, Virtual Urgent Care, Facility-Based Telemedicine</td>
<td>Monitoring of patient self reported data</td>
<td>Near-real time monitoring of streaming data from FDA approved devices</td>
<td>ICU, telemetry, remote safety</td>
</tr>
</tbody>
</table>

**CLINICAL EXPERIENCE**

**PEOPLE**

**TECHNOLOGY**

**Additional Virtual Care Opportunities**

- **e-Consults**
  - Interprofessional consultations are reported by a consulting physician who communicates with a treating provider regarding a diagnosis or management of a patient's problem.

- **Remote Patient Monitoring**
  - Involves the collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.
Myth 2: Patients feel more satisfied with an in-person versus a virtual visit

Patients feel more satisfied with their healthcare provider because they can access virtual care

- 86% of patients surveyed felt more satisfied with their provider and/or health system because they could access virtual care visits.
- Half of patients surveyed said they would be willing to switch providers to have virtual care visits on a regular basis.
- Out of ~2,850 Ascension patients surveyed, 95% were satisfied that the virtual visit met their needs and expectations.

Data source: Kyruus 2020 Patient Perspectives on Virtual Care Report; n = 1,000
Myth 3:
Virtual care is only useful in primary care

Virtual care is a foundational tool to deliver uninterrupted care and is useful in all specialties

100 VIRTUAL VISITS:

- Primary Care: 54%
- Adult Specialty: 23%
- Behavioral Health: 8%
- Adult Surgery: 3%
- Pediatric Specialty: 3%
- Pediatric General: 2%
- Women's Health: 2%
- Other: 5%
Myth 4: Only minor or common conditions can be treated through telehealth

Virtual Care can support:
- More than 80% of respondents said their virtual visits were with their existing providers*
- 30% of respondents were seen for management of chronic conditions*
- Top 5 adult chronic conditions managed via virtual care include**:
  - Diabetes
  - Hypertension
  - Behavioral Health
  - ADHD
  - Sleep Apnea

Additional Opportunities
- Annual Medicare Wellness Visits

*Data source: Kyruus 2020 Patient Perspectives on Virtual Care Report; n = 1,000
** Ascension claims data, Jan-Jul 2021 (COVID excluded)
**Myth 5:**
The challenges of implementing virtual care outweigh the benefits

Virtual Care benefits exist for the patient, clinician, and for day-to-day operations.

<table>
<thead>
<tr>
<th>Patient Benefits</th>
<th>Clinician Benefits</th>
<th>Operational Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meet the patient where they are.</td>
<td>Added scheduling flexibility.</td>
<td>Higher conversion for same day office visits.</td>
</tr>
<tr>
<td>Avoid unnecessary in-person visits, and enhance outcomes when health issues are addressed early on.</td>
<td>Enhanced care as clinicians can see directly into a patient’s home environment and identify factors that may impact health issues.</td>
<td>50% fewer no-shows for virtual vs in-person.</td>
</tr>
<tr>
<td>Alternate with in-person visits to support longitudinal care plans.</td>
<td>Improved Coordination: with up to 4 participants per encounter, including family members or other clinicians.</td>
<td>Highest and best use of in-office time to focus on procedure-based care.</td>
</tr>
<tr>
<td>Improve adherence with less of a barrier to receive care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Myth 6:
You don’t get the same attention from a clinician virtually as you do in-person

Video visits closely mirror the in-person clinician experience, without the hassle of taking time off from work

- Video visits restore some of the benefits of the house-call, allowing for assessment of:
  - Visual medication reconciliation
  - Environmental factors in the home (SDOH)
  - Many observational physical examinations
  - Inclusion of family members and caregivers
- Ascension has developed a robust quality oversight council to confirm virtual care is optimized, focusing on:
  - Appropriate antimicrobial use
  - Leveraging virtual solutions to close gaps in care - quality and SDOH

<table>
<thead>
<tr>
<th></th>
<th>Traditional</th>
<th>Virtual</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Exam</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Lab/Imaging Orders</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Med Reconciliation</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Vitals</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Rx Order</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Legend: ✔ Yes, can do ✔ Yes, modified process ❌ No, cannot do
Myth 7: Virtual care is for the Millennial generation

Virtual Care is utilized by patients of all ages

Millennials tend to leverage virtual care more for behavioral health and acute needs, while older populations manage chronic diseases with virtual care.

![Bar chart showing the percent of total virtual outpatient visits by patient age.](chart.png)

Data source: Ascension claims data, March 1-September 17, 2020
Myth 8: There is not a place for telephonic encounters

Phone visits address barriers

Phone visits address care needs for populations challenged by transportation insecurity, broadband and connectivity issues in rural and disadvantaged communities and digital literacy, particularly in older populations.

<table>
<thead>
<tr>
<th>Percent of Virtual Visits by Phone: 3/1/20 - 2/28/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>A (&lt;)</td>
</tr>
<tr>
<td>+65 years old</td>
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<tr>
<td>65+ years old</td>
</tr>
</tbody>
</table>

Neighborhood Deprivation Index (NDI)
Myth 9:
Expiration of the public health emergencies means virtual care is going away

Virtual Care was Gaining Momentum Prior to COVID-19

2019: “Payors are Responding to the Market Dynamics”

<table>
<thead>
<tr>
<th>Policy</th>
<th>Perceived Strategy</th>
<th>Sample Programs/Offerings</th>
<th>Notable Partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited coverage for network providers</td>
<td>Robust telemedicine vendor presence</td>
<td>Minor acute services Behavioral Health</td>
<td>Amwell</td>
</tr>
<tr>
<td>Limited coverage for network providers</td>
<td>Vendor alignment</td>
<td>Minor acute services Behavioral Health</td>
<td>Amwell MD Live</td>
</tr>
<tr>
<td>Establish policy which applies to most employer groups, Self-insured plans and several MA Plans</td>
<td>Expects CMS policy changes to enhance revenue growth</td>
<td>Minor acute services Designated virtual provider networks Stroke treatment</td>
<td>Doctor on Demand Amwell</td>
</tr>
<tr>
<td>Established policy which includes all products across all network and non-network providers.</td>
<td>Focused on improving care and expanding access to support value-based care and cost avoidance efforts</td>
<td>Minor acute services Designated virtual provider networks Stroke treatment</td>
<td>Doctor on Demand Vidyo</td>
</tr>
<tr>
<td>Limited coverage for network providers</td>
<td>Virtual First Employed providers</td>
<td>Minor acute services Behavioral Health</td>
<td>Teledoc</td>
</tr>
<tr>
<td>Limited coverage for network providers</td>
<td>Technology driven</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Telemedicine Reimbursement Overview

States Requiring Insurers Cover Telemedicine Services, Pre- and Post-Pandemic
(as of March 15, 2021)

Myth 10: Virtual care is not useful in addressing health disparities
Virtual Care is improving access to care in rural and underserved communities.

Virtual Care can reduce barriers to care for people who live far away from specialists or who have transportation or mobility issues. Tobacco Cessation and Diabetes Management and Prevention are examples of care that can be provided via telehealth to rural communities.

<table>
<thead>
<tr>
<th>Description</th>
<th>Tobacco Cessation</th>
<th>Diabetes Management and Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Socioeconomic factors, culture, policies, and lack of proper health care result in tobacco use impacting rural health more than what is seen in urban/metropolitan areas.</td>
<td>Nationwide, about 1 in 10 people have diabetes. Rural populations have higher rates of diabetes and lower rates of participation in diabetes self-management education and support (DSMES) services.</td>
</tr>
<tr>
<td>Potential Barrier</td>
<td>Approximately 60% of residents in rural or tribal areas have access to high-speed internet connections</td>
<td>Approximately 62% of rural counties do not have DSMES services</td>
</tr>
<tr>
<td>Telehealth Solution</td>
<td>More than 90% of rural residents own cell phones with more than 3 in 4 sending or receiving text messages. SMS texting can provide a direct channel to rural residents.</td>
<td>The CDC-led National Diabetes Prevention Program is a public-private partnership working to build a nationwide system to deliver an affordable, evidence-based lifestyle change to prevent or delay type 2 diabetes. The program can be delivered via telehealth.</td>
</tr>
</tbody>
</table>

Source: CDC "Telehealth in Rural Communities"
A Changing Regulatory Landscape

Many states are allowing public health emergencies or declarations of emergency to expire. Expiration of state emergency orders does not necessarily mean that telehealth is no longer covered by commercial or government payors.

Federal Public Health Emergency (PHE):
- The Biden administration will likely extend the PHE and associated federal telehealth waivers at least through the end of 2021.
- The administration has acknowledged the need for advanced notice for any changes.
- Congress is currently deliberating multiple bills related to telehealth. These bills - and those being considered or enacted in state capitals - are all positive signs for the future of care delivery via telehealth.

Impact of Expiration of State PHEs:
- Several states have passed legislation during their PHEs that extend telehealth flexibilities either on a permanent or temporary basis.

Commercial:
- The majority of states maintain some sort of telehealth commercial insurance coverage law. In addition, most large fully insured commercial plans had telemedicine reimbursement policies in place pre-pandemic.

Originating Sites:
- To date, there does not appear to be movement around reinstatement of originating site requirements anywhere.

Telemedicine Reimbursement Overview

States Requiring Insurers Cover Telemedicine Services, Pre- and Post-Pandemic
(as of March 15, 2021)

Requirement to cover telemedicine services pre-pandemic
Requirement to cover telemedicine services (permanently or temporarily) since pandemic

Workflows and Implementation

How: Ready? Set. Go!

1. Ready: Engage and prepare your office, staff and schedule for virtual visits
2. Set: Engage and prepare your patients for virtual visits
3. Go: Planning for before, during, and after the virtual visit

★ Measuring & maintaining success
1. **Education:** Develop education materials for clinicians and staff.

2. **Platform:** Select a HIPAA-compliant platform for your visits.

3. **Hardware:** Determine if any staff or clinicians need a webcam or headset, at home or in the office. Contact your IT department to request tools, if needed.

4. **Location:** Ensure clinicians have a private location to conduct visits.

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1. **Ready: Prepare your **office** for virtual visits**

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1. **Ready: Prepare your **schedule** for virtual visits**

   - **How will your schedule accommodate virtual visits?**
     - Create a virtual visit schedule block during the office day
     - In between in-person visits
     - Full day(s) of virtual (from home or office) and in-person
     - Working from home after-hours or non-traditional hours (weekend, holiday)

   - **Where will the staff and clinician work when conducting virtual visits?** (some visits may require direct supervision if physician is not conducting visit)
     - Clinician/staff both in office
     - Clinician/staff both at home
     - One in office, one at home
1 Ready: Prepare your staff for virtual visits

- **Huddle with staff**: Make office aware that virtual visits are available for any patient
- **Make sure staff is clear and aware of:**
  - ✓ How virtual visits work
  - ✓ Utilize checklists to ensure readiness
    - □ There is no "wrong reason" to see a patient virtually
  - ✓ Which appointments require in-person
    - □ Vaccinations
    - □ Procedures

2 Set: Engage patients using the following tactics

<table>
<thead>
<tr>
<th>Patient Outreach</th>
<th>Marketing</th>
<th>Train and script your Staff</th>
<th>Online scheduling options (if available)</th>
</tr>
</thead>
</table>
| ✓ Offer all patients calling to cancel a virtual appointment alternative | ✓ Contact your local marketing team to:  
  - Create campaign for all new physicians, highlighting virtual offering  
  - Ensure your website promotes virtual visits  
  - Offer new patient virtual visits  
  - Create fliers, handouts, email messages  
  ✓ Use templated Patient Communications | ✓ Offer virtual visits for routine follow ups:  
  "I'll schedule your follow-up as a virtual visit."  
  ✓ Write a check out note to staff indicating that visit should be booked as virtual  
  ✓ Offer a virtual alternative for cancellations:  
  "We can keep your appointment by making this a virtual visit with your doctor" | ✓ Let your patients know they can self-schedule appointments.  
  ✓ Emphasize convenience and flexibility of self-scheduling.  
  ✓ Note this is the same way patients book in-person appointments. |
2. Set: Engage patients using the following tactics

Patient Outreach → Announce that your practice now offers virtual care

Announce offering via email, mail, text, e-boards or digital displays and/or on-hold messaging. Talking points include:

- [CLINICIAN NAME] is now offering scheduled virtual visits (also called telehealth visits) in addition to in-person care.
- Virtual visits help you get the care you need from wherever you are, with your same doctor.
- A virtual visit can be done from your phone, tablet or computer, as long as there is a forward-facing camera. It is private and secure.
- You get the same personalized, compassionate care that you have come to expect.
- You can connect to your doctor for a virtual visit with a simple click of a button. If you have any questions, we can walk you through each step of the way.

Promote virtual care with marketing tools for your office and website.

- Contact your local marketing team to ensure your website promotes virtual visits and that new physicians have a specific campaign promoting virtual offering.

3. Go: Scheduling Appointments

When scheduling or confirming virtual appointments:

- ✓ Determine if medical translation services are needed.
- ✓ Ask if the patient would like a family member or caregiver join the visit.
- ✓ Remind them to test their technology prior to the visit (i.e. browser setting, camera and microphone access).
- ✓ Let the patient know who they can contact if there are tech issues (medical assistant or practice manager).
- ✓ Verify the patient understands how / when they will receive a visit link.
3 Go: Operationalizing the virtual visit

Key considerations to prepare for virtual visits

<table>
<thead>
<tr>
<th>Outgoing callings to patients</th>
<th>Patient forms &amp; signatures</th>
<th>Send a visit link</th>
<th>Communication between clinician &amp; staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine if you need a private number to make outgoing calls to patients, to avoid using your personal number. Google Voice creates an internet-based number to mask your personal number.</td>
<td>Determine how you will obtain patient signatures on consent forms, or how they will fill out new patient intake forms.</td>
<td>Determine how you will send patients a virtual visit link. This may be directed by the platform you choose, but is typically via email or text.</td>
<td>Determine communication between clinician &amp; staff before, during and after visit (secure text, call). Option: MA/RN can connect with patient first, do an intake and initial history (just like “rooming” an in-office patient); and send MD a link when patient is “ready” to be seen. Indicate in the EHR schedule that the patient is ready for the visit</td>
</tr>
</tbody>
</table>

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3 Go: Communication

Clear communication among office staff is essential to a successful Virtual Visit Program. Solutions should be discussed and agreed upon in advance to ensure seamless processes.

<table>
<thead>
<tr>
<th>Process Item</th>
<th>Possible Solution(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notifying the <strong>clinician</strong> that the patient is ready to be seen.</td>
<td>Google Chat, Volte, secure text message, schedule color coding, de-identified text message (i.e., “patient is ready”)</td>
</tr>
<tr>
<td>Notifying the <strong>clinical staff</strong> that the patient is ready for discharge.</td>
<td></td>
</tr>
<tr>
<td>Notifying the <strong>patient</strong> if the clinician is running late</td>
<td>Send text; phone call to patient</td>
</tr>
<tr>
<td>Notifying the <strong>clinician</strong> if the patient is running late</td>
<td>Your practice’s preferred communication method</td>
</tr>
</tbody>
</table>
### Go: Day of appointment

**Clinical Staff**
- Check in patient by phone or video
- Invite medical interpreter if needed
- Complete intake data and vitals
- Alert Clinician that patient is ready

**Clinician**
- Connect to video
- Review & obtain consent for virtual services with patient
- Assess patient
- End video

**Clinical Staff**
- Complete SOAP note and place orders/meds
- Notify staff that patient is ready for discharge
- Indicate if follow-up visit should be virtual

**Office Manager**
- Add modifiers (GT or 95)
- Ensure proper place of service
- Ensure visit notes includes: *Pt was seen via two-way secured video for a virtual visit*

### Measuring & maintaining success

**1. Set goals for virtual**
- Improve gap in care closure
- Reduce no-shows
- New Patient Acquisition/Practice Growth

**2. Establish frequent staff huddles**
- Identify opportunities to achieve goals
- Review workflows that work or can be improved
- Discuss patient feedback

**3. Develop care models**
- Chronic disease management
- Bundled payments
- Episodic payments

**4. Track progress**
- Summary Reports
- Monthly Dashboards
Opportunities with Remote Patient Monitoring (RPM)

This Year, Ascension is Focused on the CMS Definition of RPM

- **Communication technology based services**
  - Image/video upload e-consults

- **Synchronous Video**
  - Telemedicine

- **Patient Surveillance**
  - Monitoring of patient self reported data
  - Bots, symptom checkers, consumer devices
  - Self service tools, Digital Therapeutics

- **Connected Devices**
  - Near-real time monitoring of streaming data from FDA approved devices
  - Biosensors, Glucometers, BP Cuffs

- **Facility Patient Monitoring**
  - ICU, telemetry, remote safety

*SPECTRUM OF RPM SERVICES

**CLINICAL EXPERIENCE**

**PEOPLE**

**TECHNOLOGY**

*CMS Definition of RPM
Why is RPM Important?

RPM involves the collection and analysis of patient physiologic data that is used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition. RPM allows for clinicians to obtain critical “alert” values as well as trends of patient data over time to inform treatment decisions.

- **PATIENT ENGAGEMENT**: Interact with patients between visits, educate and change behaviors.
- **TIMELY TREATMENT**: Equip treating physician with near-real time data insights for early intervention.
- **HEALTHY AT HOME**: Patients in RPM programs report improved quality of life.
- **REDUCED COST OF CARE**: Reduce non-essential office visits, prevent hospital admissions and ER visits.

Key Elements of a Successful RPM Program

1. **IDENTIFICATION AND ENGAGEMENT**: Smart analytics to identify patient segments most likely to benefit.
2. **CLINICAL INTERVENTION**: Integrated care teams and actionable data in the hands of the treating physician.
3. **OUTCOMES**: Clearly defined success metrics.
4. **TECHNOLOGY AND SCALE**: Allowing for just-in-time, relevant information to care teams and patients.
Future State: A “Digital” Formulary

Digital Therapeutics
Wearables
mHealth apps
Biosensors
PROs

Digital coaching
FDA Cleared Devices

Smart Pill Bottles
Visual med adherence

Simplified Front End Patient Experience

We will soon have the ability to “prescribe” not just medications but entire remote monitoring solutions to patients as part of treatment plans.

Give Clinicians the Ability to Choose Best in Class Option

These will go through similar FDA approval processes as medications

Summary

Digital technologies have rapidly penetrated many aspects of people’s interactions with healthcare organizations and will soon be table stakes.

- As we learned with synchronous video visits, RPM should not be considered a novelty, but instead an integral way in which we deliver care to patients
- RPM should be considered a key aspect of value-based arrangements, assuring patient/clinician engagement and timely treatment
- RPM can improve quality and reduce cost of care when applied to the appropriate patient populations
- Technology solution(s) should be simple, scalable and focus on our 3 main “customers”, physicians, clinical staff, and patients
Where do we go from here?

1. Monitor policy developments and advocate strongly that Congress and the Administration take action to support ongoing access to virtual care.
2. Leverage post-COVID telemedicine progress and momentum within your organization.
4. Explore new opportunities for Telemedicine and Digital Health in your organization (i.e., Remote Patient Monitoring).
Telemedicine Billing and Coding after the Pandemic:

*Practical Tips for the Practicing Allergist*

Sakina S. Bajowala, MD

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**Overview**

- Historical restrictions on coverage and reimbursement
- COVID-19’s impact on telemedicine regulation & reimbursement
- Billing for virtual health services
- Importance of internal audits
- Future of telemedicine reimbursement post-PHE
Telemedicine coverage & reimbursement restrictions

- Geographic restrictions
  - Rural areas
  - Originating site requirements
- Coverage restrictions
  - Limited coverage for new patients
  - Narrow telehealth networks
- Payment restrictions
  - Lower reimbursement vs in-person visits
  - Payment parity mandated by only a handful of states
- Regulatory variability
  - Plan, Carrier, State

Billing & coding for common virtual health services

- Virtual check-in
- Remote evaluation of video/image
- Telephone visit
- E-visit
- Standard E/M
Virtual check-in:

G2012
Usual POS
No modifier
$14.66 / $13.26
(non-facility/facility)

• Brief (5-10 min) synchronous audio or audio-video interaction between patient and provider (MD, DO, PA, NP) to determine need for further evaluation
• Cannot arise from a previous E/M visit in the last 7 days or result in an E/M visit in the next 24 hrs (or next available)

NEW in 2021: This code is not subject to Section 1135 PHE waivers, and will survive the public health emergency, regardless of patient location.

Virtual check-in:

G2252
Usual POS
No modifier
$25.47 / $25.47
(non-facility/facility)

• Intermediate (11-20 min) synchronous audio or audio-video interaction between patient and provider (MD, DO, PA, NP) to determine need for further evaluation
• Cannot arise from a previous E/M visit in the last 7 days or result in an E/M visit in the next 24 hrs (or next available)
Remote evaluation of patient-submitted images & video:

G2010
Usual POS
No Modifier
$12.21 / $9.42
(non-facility/facility)

- Provider reviews and provides guidance on images or video submitted by established patient (rash, angioedema, barky cough, etc.)

Telephone visit:

99441-3
Usual POS
modifier -95

$56.88-$131.55;
$36.29-$100.84
(non-facility/facility)

- Synchronous audio-only evaluation and management initiated by patient and performed by provider (MD/DO, PA, NP) – during PHE, OK for New Patient
- Not arising from E/M in last 7 days or resulting in new E/M asap
- Time-based
  - 99441: 5-10 min
  - 99442: 11-20 min
  - 99443: 21-30 min
- CMS & Aetna reimbursement temporarily equivalent to 99212-4
- Cigna, Humana, UHC permitted billing for telephone visits as face-to-face E/M codes during PHE telehealth expansion
**Telephone visit:**

99441-3
Usual POS
No modifier
$46.19-$110.43;
$26.35-$80.48
(non-facility/facility)

- Synchronous audio-only evaluation and management initiated by patient and performed by provider (MD/DO, PA, NP) – during PHE, OK for New Patient
- CMS reimbursement for telephone-only evaluation will expire post-PHE – plan to use G2012 & G2252 (virtual check-in) instead
- CMS & Aetna reimbursement temporarily equivalent to 99212
- Cigna, Humana, UHC permitted billing for telephone visits as face-to-face E/M codes during PHE telehealth expansion

**Digital health evaluation (e-visit):**

99421-3
Usual POS
No modifier
$15.00-$47.46;
$12.91-$41.17
(non-facility/facility)

- Non face-to-face patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office
- Not arising from E/M in last 7 days or resulting in new E/M asap
- Using a secure platform (ie: HIPAA-compliant patient portal or secure email)
- Bill only once in a 7-day period, based on cumulative time spent in review/research/response
  - 99421: 5-10 min
  - 99422: 11-20 min
  - 99423: 21 or more min
- If results in E/M within 7 days of initiation, roll time into E/M level instead of billing e-visit separately
### New patient E/M:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time Range</th>
<th>Rate Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201-5</td>
<td></td>
<td></td>
<td>$73.97-$224.36; $49.90-$186.68</td>
</tr>
</tbody>
</table>

* Usual POS* Modifier -95

- Must be delivered via synchronous audio-video connection
- Exceptions include Cigna, Humana, UHC, which are temporarily permitting audio-only E/M
- Bill based on time (total time spent by clinician on day of service, rather than only on counseling/coordination of care) or medical decision-making (MDM)
  - 99202: 15-29 min
  - 99203: 30-44 min
  - 99204: 45-59 min
  - 99205: 60-74 min
  - 99417 (CPT prolonged service, in 15 min increments): 75-89 min
  - G2212 (CMS prolonged service): 89-103 min

* Use POS “02” for Tricare & Aetna

### Established patient E/M:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time Range</th>
<th>Rate Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211-5</td>
<td></td>
<td></td>
<td>$23.03-$183.19; $9.07-$147.95</td>
</tr>
</tbody>
</table>

* Usual POS* Modifier -95

- Must be delivered via synchronous audio-video connection
- Exceptions include Cigna, Humana, UHC, which are temporarily permitting audio-only E/M
- Bill based on time (total time spent by clinician on day of service, rather than only on counseling/coordination of care) or medical decision-making (MDM)
  - 99211: 5-9 min
  - 99212: 10-19 min
  - 99213: 20-29 min
  - 99214: 30-39 min
  - 99215: 40-54 min
  - 99417 (CPT prolonged service, in 15 min increments): 55-69 min
  - G2212 (CMS prolonged service): 69-83 min

* Use POS “02” for Tricare & Aetna
Importance of internal audits

- Obtain consent
  - Patient must be informed that service will be billed, and agree to service
  - Consent must be documented in the record
    - Check with your state
- Use the correct POS and modifier
  - Some payers only pay with parity to in-person rates when using POS “11” and modifier -95 or -GT
  - Others mandate the use of POS 02 to signify telehealth services
- Check your fee schedule
  - Have you updated your telephone visit charges to be at least equal to your 99212-4 reimbursement?
- Stay up to date
  - Guidelines are in flux. Stay on top of changes and expiration dates.

Future of telemedicine reimbursement

- Telehealth expansion waivers won’t last forever
  - But we also can’t go back to baseline
- CMS moving to make some PHE-related changes permanent
  - Adding services permanently to telehealth list
  - Lifting originating site requirements and geographic restrictions will be tricky, and may require Congressional intervention
- Parity
  - Increased coverage parity is likely, as patients will demand the ability to receive telehealth from established physicians
  - Payment parity will be more difficult to achieve, given concerns over over-utilization, fraud, and budgeting
    - If achieved, will likely be bundled with patient cost-share to limit over-utilization
- Technology
  - Prepare now for secure, end-to-end encryption and HIPAA-compliance
Impact of PHE on telemedicine expansion

• Coverage parity
  ✓ New patients
  ✗ Telephone care
  ✓ Virtual check-in, Remote evaluation, E-visit
  ✗ Out of network coverage

• Payment parity
  ✓ CMS → Private payers
  ✗ Waiver of cost-share

• Regulatory relaxation
  ? Lifting of geographic restrictions
  ? Practice across state lines
  ✗ HHS enforcement discretion

• Capture previously lost revenue from uncompensated care

Final Takeaways

• The COVID-19 public health emergency has significantly accelerated the pace of telehealth expansion in the United States.

• Gaining familiarity with a handful of codes and modifiers will enable you to bill for a broad spectrum of telehealth services.

• Periodic audits of your own coding and reimbursement can ensure that any billing mistakes are corrected as early as possible.

• Telehealth reimbursement policies are in a state of flux, so it is important to stay abreast of federal-, state-, and payer-specific guidelines to ensure you are compensated appropriately.
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