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Telehealth: Helping Your Patients and Practice Survive and Thrive During the COVID-19 Crisis with Rapid Quality Implementation

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Telehealth: Helping Your Patients and Practice Survive and Thrive During the COVID-19 Crisis with Rapid Quality Implementation

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Telehealth is an effective, efficient way to triage and deliver timely, quality medical care. In the setting of this public health emergency, telemedicine can maintain access and continuity of care for patients, support colleagues on the front-line, optimize in-person services, and minimize infectious transmission of COVID-19 coronavirus.

On March 17, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a 1135 Waiver and expanded telehealth coverage for all Medicare patients during the COVID-19 pandemic.

What does this mean for clinical practitioners? In short, telemedicine can be used for evaluation and management of most patients. CMS's policy changes effectively eliminate the main barriers to telemedicine implementation: lack of reimbursement, licensing restrictions, and HIPAA compliance. Given current CDC guidelines, in-person care should be limited to only the most urgent patients; this minimizes risk of COVID-19 transmission and ensures that finite clinical resources will be equitably distributed to those that need it most.

In the CMS guidance,[1] many restrictions that have roadblocked telehealth adoption for decades have been removed to promote "good faith use of telehealth" in these unprecedented times. To preserve both patient and society's trust, medical communities must hold our standards for professionalism and quality care high. Adherence to state regulations,[2] thorough clinical intake, clear and consistent video connectivity and images, documentation, patient education and transparency, care coordination, data security, and patient privacy should remain a top priority, even in times of crisis. If a non-HIPAA compliant platform is used initially, conversion to a HIPAA-compliant platform should be encouraged as soon as possible.

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Telehealth offers a tool to provide accessible, quality care and maintain connectivity while practicing social distancing. Thoughtful implementation[3,4,5] of telehealth now allows for sustainable and scalable practice beyond the current crisis.

We recommend the following steps for implementing telemedicine into outpatient practices:

1. Use existing systems and platforms (patient portals) to encourage patients to initiate telemedicine when available.
2. Identify highest risk or urgent patients and schedule them for telemedicine visits.
3. Defer all non-essential visits until a later time.
4. Develop an established pathway for contact/evaluation for urgent patients.
5. Make sure patients know there is a clear line of communication to minimize emergency department overuse for non-critical issues.

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In the last weeks, we have been proud of the quick actions of our colleagues to adapt and change their way of practice. However, there will always be questions as clinicians change the way they practice. Will telemedicine provide the same quality care as in person? How can we foster patient relationships with electronic distance? Unfortunately, we do not have the resources to see most patients in person, nor can we risk exposing otherwise healthy people to COVID-19. With telehealth implementation, we can see patients remotely, whereas we would not have seen them at all.

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We anticipate that these changes are necessarily difficult, and our system will grow in new ways. Together as physicians, we will inevitably learn new things about allocating resources, improving efficiency, and optimizing our health system by using telehealth to tackle this pandemic.

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Table. Updates in Telehealth Policy in the COVID-19 Crisis

	Pre-COVID-19 Telehealth Policy	COVID-19
Physician Licensure	Providers must be licensed in state of the patient	Waived.
Patient Population	Established patient of the practice (within 3 years)	Not enforced. ♦
Patient Location	Eligible originating sites, Rural communities (HRSA)	All settings, including patient's home.
Technology[6]	Synchronous (live-interactive) Asynchronous (store & forward)	No change.
Privacy & Security	HIPAA compliance	Not enforced.♦
Synchronous E-visit (Provider to Patient)	Codes: 99201-99215 Place of Service code: POS 02 Co-insurance and deductibles apply. Retroactive coverage to March 6, 2020	Must use an interactive audio and video telecommunications system that permits real-time communication between the distant site and the patient at home to be reimbursed at the same amount as in-person visits. Providers have flexibility in reducing/waiving out-of-pocket costs for patients.
Asynchronous E-visit using Patient Portal (Provider to Patient)	Codes: 99421-3 Place of Service code: POS 02 Established patients only.	No change.
Interprofessional E-Consultations (Provider to Provider)	Synchronous, asynchronous, or telephone Codes: 99446-99452 Place of Service code: POS 11	No change.
Virtual Check-in (Provider to Patient)	Synchronous, asynchronous, or telephone -Patient initiated -Established patients only -Brief, 5-10 minutes -Cannot result/lead to E/M service within previous 7 days or next 24 hours. -Low reimbursement Codes: G2010 (asynchronous) G2012 (synchronous) Place of Service code: POS 02	No change

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Other Payers		
Medicaid	by State[2]	Evolving by state
Private	By State[2] Billing modifier 95 (synchronous)	Evolving[3]

+Please see AAD Telederm Toolkit for the most up to date codes and resources.[3]

♦ The Department of Health and Human Services (HHS) is announcing a policy of *enforcement discretion* for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Coronavirus Preparedness and Response Supplemental Appropriations Act.

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