Osteopathic Family Physician | Volume 12, No. 5 | September/October, 2020

REVIEW ARTICLE

TELEMEDICINE DURING A PANDEMIC WITH OSTEOPATHIC CONSIDERATIONS

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KEYWORDS:

Billing

Coding

Empathy

Legal Considerations

Practice Management

Telemedicine

ABSTRACT: Health care continues to make strides in the industry by incorporating technological innovation to capture consumer demand and financial growth. Over the past 10 years, significant technology advances in health care include developing electronic health records, patient portals, self-service kiosks, remote monitoring devices, genome sequencing and telemedicine. The topics covered include visit how-to's, presenting yourself professionally, displaying empathy and treating the whole person in the virtual platform. Practice management topics include benefits of telemedicine, billing and coding, reimbursement, and legal consideration. Multiple tables display various topics, including different types of telemedicine, different virtual platforms, CPT codes to code the visit and billing modifiers associated with telemedicine.

INTRODUCTION

Telemedicine history dates to its first successful launch back to the 1960s when NASA developed it to find ways to improve telecommunication technology to provide health care to astronauts.[1] In 2013, the future of telehealth started to emerge, with 52% of hospitals using its features in some capacity.[2] The following year in 2014, eVisit launched. Before the COVID-19 pandemic, telehealth's focus areas included mental health, specialist care and improving the delivery of care for those in rural areas across the U.S. It was already expected that in 2020 that telehealth visits would increase to 158 million from 19 million.[3] Primary care has been forced to transition to virtual visits with the current pandemic and as a result, this projected number will likely be exceeded. In April 2020, my health network conducted 80,000 virtual visits, with half performed by primary care providers, to protect both patients and providers from COVID-19.

Before the pandemic, telemedicine was drastically different. The Centers for Medicare and Medicaid Services (CMS) has been promoting telemedicine services since 1999. However, it had limited criteria. These criteria include the beneficiary receiving those services must be located in a designated rural area and the visit would have to be conducted in a medical facility, known as an originating site. With the start of the COVID-19 pandemic, CMS approved the 1135 waiver, which is a disaster proclamation effective for services starting March 6, 2020 and to last for the duration of the COVID-19 public health emergency. The waiver states that Medicare reimburses for Medicare telehealth services furnished to beneficiaries in any health care facility and their home.[4,14] Medicare can also pay for office, hospital and other visits furnished via telehealth across the country in the patient's place of residence starting March 6, 2020. There are four main technology applications under telemedicine: synchronous live video conferencing, synchronous (store and forward), remote patient monitoring and mobile health (Figure 1)[8,13]

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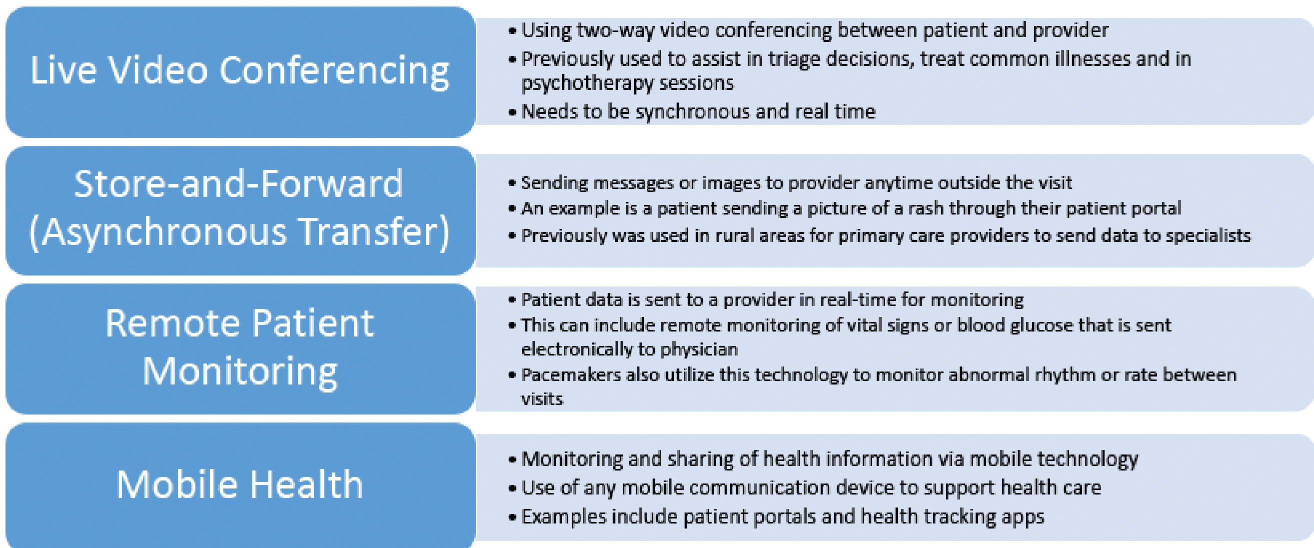
DOI: 10.33181/12052

FIGURE 1:

Types of telemedicine technology



VISIT HOW-TO'S

Technology has evolved in a way that makes conducting telemedicine easy and convenient. Most smartphones and computers are embedded with webcams that are capable of performing these virtual visits. There are many telemedicine platforms, some of which are HIPAA compliant, while others such as Facetime and Skype are not. HIPAA regulations are being relaxed during the pandemic, and these regulations will likely be the first to be adjusted post-pandemic. Providers might utilize these platforms in the beginning as they set up telemedicine services to generate early success. However, they will need to adjust to a HIPAA compliant platform for patient care as they get comfortable with the permanent telemedicine platform that they choose. Some platforms can be incorporated directly into the electronic medical records (EMR) or the health network's phone app, especially practices within an extensive network. During the pandemic, many platforms are offering free trials. This will give the practice time to get comfortable finding a platform that works for their needs. Be sure to know the ongoing fees, such as yearly, monthly or hourly costs to the practice. Check with your existing EHR vendor to see if there is telehealth functionality that can be turned on. Also, consider reaching out to your state medical association on vendor evaluation, selection and contracting. For examples of common telemedicine platforms utilized during the current pandemic see Table 1.[14]

TABLE 1:

Common telemedicine platforms used in the pandemic[14]

Telemedicine Platform	HIPPA Compliant	Mobile App
Amazon Chime	✓	✓
American Well	✓	
Apple Facetime		✓
Blue Jeans for Health Care	✓	✓
Cisco Webex Meetings	✓	✓
Doximity Video	✓	
Doxy.me	✓	
Google Duo		✓
GoToMeeting	✓	✓
MDLive	✓	✓
Medici	✓	✓
Mend Telemedicine	✓	✓
Microsoft teams	✓	✓
Noteworth	✓	✓
Skype for Business	✓ *	✓
Teladoc	✓	✓
What's App		✓
Zoom for Health Care	✓	✓

Present Professionally

Before the telehealth visit, ensure the video device is stable. Providers can utilize video capabilities from a laptop, desktop camera or the provider's mobile device. Ideally, the patient should be able to see the provider from the shoulders up. The provider should be directly facing the screen and avoid turning away from the camera to engage with direct eye contact. This also allows the ability of the provider to capture their hands on the screen for gesturing. If possible, set up in a room where the provider can take off their mask to demonstrate facial expressions to the patient. Take caution to what may be situated behind the provider and any external noise. Identify yourself with credentials by showing your I.D. on the screen. Ensure to correctly identify the patient with their name and date of birth before the visit starts. If attention is taken away from the screen, do not hesitate to explain to the patient why this is happening, such as charting or placing orders on the computer.

Empathy

When utilizing telemedicine, we lose physical touch - something that an osteopathic and primary care physician fosters daily. Even though we cannot reach through the phone to examine our patients, we can still show our patients empathy in the virtual encounter. This can be accomplished by fostering a supportive environment by active listening, asking open-ended questions and responding to cues with support.[5] Nonverbal displays of empathy are a major aspect of our everyday communication and can still be displayed on a screen.[5] As providers, we can demonstrate these nonverbal displays by maintaining eye contact, showing emotional concern through facial expressions or demonstrating active listening with an occasional head nod. Patients will display nonverbal cues by changes in their facial expressions or verbal cues by stating words of emotion, such as "worried" or "afraid."[5] It is also important as providers that we try to focus on not interrupting the patient, as it can lead to increased patient frustration on the virtual platform.

Treat the Whole Person

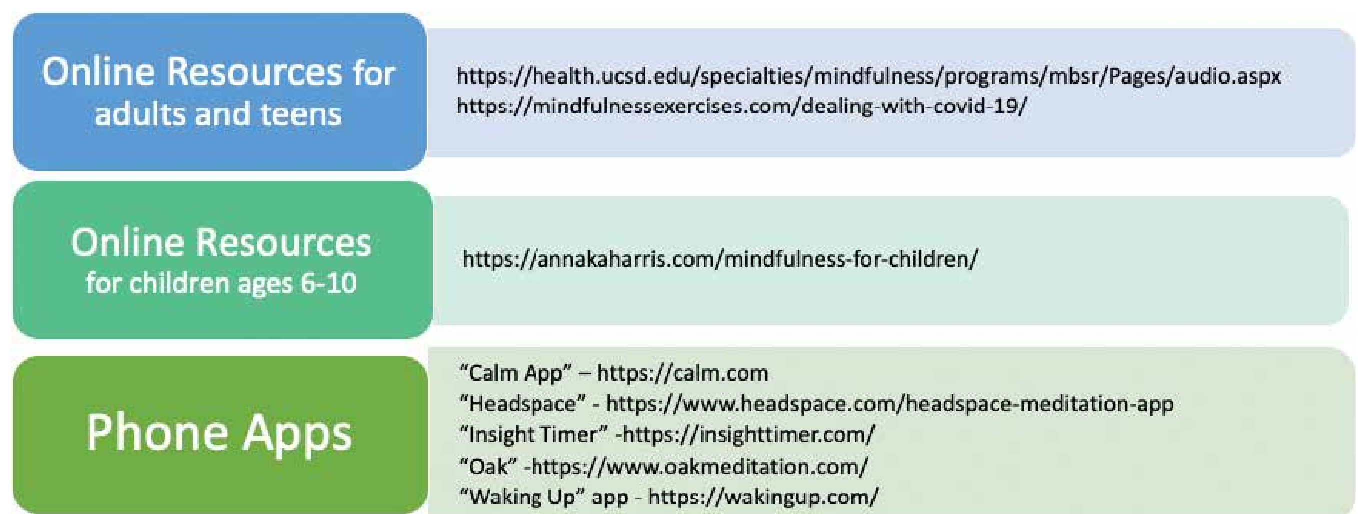
Our osteopathic imprint allows us to focus on our osteopathic tenets, such as treating the whole person with the interrelation of mind, body and spirit. We have unique training to recognize patient distress signals. Our patients have an extreme increase in anxiety during the pandemic due to lockdowns, battling illness, loss of income or employment and grief from lost loved ones. We can guide our patients to cope with this increase in stress.

Research shows that physicians that have an empathic relationship with their patient can positively impact patient outcomes such as improving self-efficacy, compliance to treatment plans and decrease psychological stress.[6] Advise patients to keep a consistent schedule that includes self-care. Self-care may look different in quarantine but can still be accomplished. Encourage patients to reduce exposure to news and media, utilize the extra time to exercise regularly and direct them to online mindfulness resources. (Figure 2)[7]

Extending a helpful hand by incorporating osteopathic manual medicine does not have to halt in the virtual visit altogether. Providers can teach patients simple techniques that a caregiver at home can perform or that the patient can perform on themselves. Taking the time to explain simple techniques to patients will improve the provider-patient relationship and increase patient gratitude. (The OFP Patient Education Handout: Osteopathic Home Exercises for Caregivers of COVID-19 Patients available for download at acofp.org/peh)

FIGURE 2:

Online mindfulness resources[7]



PRACTICE MANAGEMENT ASPECTS

Benefits of Telemedicine to the Provider and Patient

The benefits of telemedicine begin at the patient level and expand to the provider. It is especially cost-saving and convenient for the patient, who will incur fewer travel costs, and missed work, plus it allows them to receive care faster. It may also benefit the provider's practice to decrease no show rates or in special scenarios such as inclement weather. The geographic footprint of the provider has the potential to expand to further patient locations, while, at the same time, improving patient satisfaction scores. Many primary care providers may adjust to a blended practice utilizing telemedicine combined with remote patient monitoring for some routine follow-ups, managing recently discharged patients or medication changes such as titrating insulin regimens. The physician can use remote patient monitoring such as automatic blood pressure cuffs, digital scales, blood glucose monitors and other health tracking apps to receive vital data to manage chronic conditions such as diabetes or hypertension. This blended model could decrease readmission rates, no show rates and cost of patient transportation, ultimately reducing health care costs by an estimated $1.8 billion over the next ten years.[8]

TABLE 2:

National telemedicine CPT codes for Medicare plans and some commercial insurers[16]

Payer/Plan	CPT codes	Audio/Video
Medicare Plans: CMS Medicare Aetna Medicare Advantage Humana Medicare Advantage	99201-99215 G2012 99441-99443	Video Required Telephone Allowed Telephone Allowed
Add Modifier CS to Medicare Claims with (COVID) Reason for Visit to get Cost Sharing Waiver		
Aetna Commercial	99201-99215 99441 to 99443 G2012	Video Required Telephone Allowed Telephone Allowed
Cigna	99201 to 99215 G2012 99441-99443	Telephone Call Allowed Telephone Call Allowed Telephone Call Allowed
Humana Commercial	99201-99215 99241-99245 99441-99443 G2012	Video Required Video Required Telephone Call Allowed Telephone Call Allowed
UHC Commercial UHC Medicare Advantage	99201-99215 G2012 99441-99443	Telephone Call Allowed Telephone Call Allowed Telephone Call Allowed
Blue Cross and Blue Shield – State Dependent for CPT codes and Video/Telephone Requirements		
For commercial coverage by state visit https://www.empclaims.com/ and select “Access Telemedicine Billing Guide” or https://osteopathic.org/practicing-medicine/telemedicine/ and select “Telehealth Guide” to reach the same state specific excel sheet		

TABLE 3:

New CMS HCPS codes for virtual check-in[9]

Code	Description	2020 wRVU	National non-facility / facility payment
G2012	Brief communication technology-based service, i.e., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.	0.25	$14.8/13.35
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g, store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.	0.18	$12.27/9.93

TABLE 4:

New CMS HCPS codes for telephone visits[4,14,17]

Code	Time	2020 wRVUs	Medicare Reimbursement (non-facility/facility)	Non-Medicare Reimbursement
99441	5-10 minutes	0.48	46.13 / 26.31	$12.50 to $15.25
99442	11-20 minutes	0.97	76.04 / 52.26	$23.00 to $29.50
99443	21-30 minutes of medical discussion	1.50	110.28 / 80.37	$33.75 to $44.00
Telephone Encounter Description: "Telephone evaluation and management service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment." [4,17]				

TABLE 5:

Telemedicine modifiers

95 Modifier

Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system. Append this modifier to an appropriate CPT code (listed in Appendix P in CPT manual) for a real time interaction between a physician or other qualified healthcare professional and a patient who is located at a distant site from the reporting provider.

GT Modifier

Interactive audio and video telecommunication systems. Use only when directed by your payor in lieu of modifier 95

CS Modifier

Under the Public Health Emergency (PHE) patients will not be held responsible for deductibles, co-insurance or copayments for certain services they receive as part of their care for COVID.

TABLE 6:

Additional HCPCS and CPT codes allowed for telemedicine by CMS during the COVID-19 pandemic

CPT/HCPCS Code	Short Description	CPT/HCPCS Code	Short Description
99281-99285	ED Visits	99477-99480	Initial/Subsequent Intensive Care
99218-99220	Observation Initial Care	99291-99292	Hourly Critical Care
99224-99226	Subsequent Observation Care	99468-99473	Initial Critical NICU/PICU
99234-99236	Same Day Admit/Discharge	99315-99316	Nursing Facility Discharge
99217	Observation Discharge	99483	Care Planning

Reimbursement of a Telemedicine Visit

CMS offers equal reimbursement for telemedicine visits as in person-visits, as well as increasing the payment of telephone visits codes when all documentation requirements are adequately satisfied. (Table 4)[4, 14,17] On April 30, officials at the CMS announced the temporary telephone visit rate increase from $14–$41 per visit to about $46–$110 as well as expanded eligible services, including patient education services.[12] This pay increase will retroactively take effect from March 1, 2020. Private payors' reimbursement depends on the state and negotiated reimbursement rates with that private payor.

States with telemedicine parity law in place have the best reimbursement.[8] When a state passes a telemedicine parity law, it means private payors in that state have to reimburse for telemedicine care in the same way they would for in-person care. Twenty-nine states have passed parity laws for telemedicine, including eight additional states that have proposed parity laws pending in-state legislation. The five biggest commercial insurers are Aetna, Cigna, Blue Cross-Blue Shield, Humana and United Health Car. Commercial payors are always increasing telemedicine coverage due to cost-saving benefits and consumer demand. For a detailed summary of parity law in your state, visit: *https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies*

Legal Considerations

There are many legal considerations as a health care provider such as credentialing and malpractice insurance - telemedicine is not immune to these considerations. First and foremost, you must be credentialed and licensed in the state that you are conducting telemedicine visits. In most cases, the patient must also be located in the state that you are in when doing these visits; this rule varies by state. The Interstate Medical Licensure Compact has also allowed health care providers to extend their patient population and there have recently been states added to this during the pandemic to help hard-hit states. Also, you must check with your malpractice insurance carrier to ensure your policy has coverage for telemedicine visits, as this may reveal a gap in protection for the provider. Some states have placed restrictions on certain medications that can be prescribed via telemedicine, especially in cases where the patient is new to the provider as well as controlled substances.[8]

Informed consent is also an important aspect to make sure patients understand the basic procedures of telemedicine as well as the potential privacy risks. Some states have instituted requirements for consents that are specifically for telemedicine. Some practices may embed this telemedicine statement into their general consent for treatment as well as in the note template to be rehearsed with the patient during the time of the visit. This may include statements such as a "full exam cannot be completed" or directly notifying the patient when a non-HIPAA compliant platform is used. There are multiple areas of content to include in the telemedicine consent beyond risks, benefits and alternatives. These include a description of telemedicine care, types of transmissions permitted (i.e., prescription refills or education), privacy and security risks and safeguards, technical failure risks, the physician determines if care if appropriate for telemedicine, physician misdiagnosis or mistakes due to nature of video visits and where to go for ongoing care.[8]

CONCLUSION

Telemedicine continues to make strides in technological advancements as well as reimbursement to providers. With the COVID-19 pandemic, telemedicine has become embedded into primary care, allowing providers to reach their patients in the comfort of their homes while decreasing office no-show rates. More and more payors will allow for telemedicine as they uncover cost-saving advantages and have increased customer demand. The pandemic has improved Interstate Medical Licensure Compact and quickly broadened states participating in telemedicine parity

laws resulting in better reimbursement and further provider outreach. A future practice with a blended telemedicine model can decrease health care costs, increase patient compliance and health outcomes, and start to take steps to close the gap for health care disparities.

AUTHOR DISCLOSURES:

The author(s) declare no relevant financial affiliations or conflicts of interest.

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