Telemedicine Policy, Documentation and Billing

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Disclosures

- I have served on an Advisory Board for Gilead Sciences
- I serve on the Pharmacy and Therapeutics Cmte for Premera Blue Cross (WA/AK)

Objectives

- To describe how to document a telemedicine visit
- To list what types of telehealth are reimbursable

What changed with COVID19?

PRE-COVID FOUNDATION

- Growth in telemedicine steady and consistent
- Cheaper, easier to use and more reliable technology
- Increasing consumer comfort level with technology
- Many digital natives entering workforce
- Improving reimbursement landscape
- Good fit for volume to value

POST-COVID **CHANGES**

- Stay at home orders in every state
- Preservation of PPE, limited testing, and protection of HCW and resources
- Need for technology to help with triage of potential SARS-Cov2 infected patients as well as ongoing care of chronic diseases
- Many barriers removed to telemedicine (technology, reimbursement, licensing)

Acknowledgement: Joe Kvedar, MD

Telehealth Policy Changes (CMS)

- Centers for Medicare and Medicaid Services released waivers to increase access to and coverage for telehealth during COVID-19*
- Key waivers** relevant for ambulatory providers include:
  - No geographic restrictions
  - Patients are allowed to be home during telehealth interactions
  - Providers are able to provide services when at home
  - Reimbursement for 180 different codes, including codes for live video and audio-only telephone
  - Reimbursement rates are the same as if services had been provided in-person. Audio reimbursement rates have also been increased
- Future extension of waivers unknown

*Policies for FQHC/RHC facilities vary
**Summary of all of waivers here

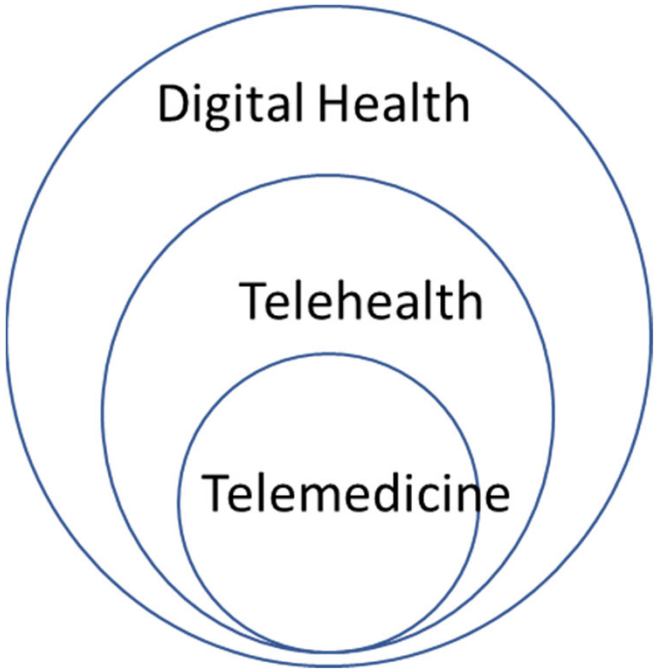
“The genie’s out of the bottle”

"I think the genie's out of the bottle on this one," Seema Verma, the CMS administrator, said. "I think it's fair to say that the advent of telehealth has been just completely accelerated, that it’s taken this crisis to push us to a new frontier, but there's absolutely no going back."

https://www.beckershospitalreview.com/telehealth/the-genie-s-out-of-the-bottle-on-this-one-seema-verma-hints-at-the-future-of-telehealth-for-cms-beneficiaries.html

But first, some definitions

- ✓ Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."
- ✓ Often used interchangeably with telemedicine, but telemedicine is technically focused on clinical aspects of care.
- ✓ Digital and connected health is defined as the use of digital, mobile, wearable, or other innovative technologies that facilitate the tracking and monitoring of health status and behavior outside the clinical encounter, with the goal of fostering more patient-centered, technology-enabled, and insight-driven healthcare.



https://www.hrsa.gov/telehealth/

How is a virtual visit different from an in-person visit?

- **Preparation:** Getting vital signs, forms signed
- **Technology:** More moving parts
- **Documentation and billing:** Just slightly different
- **Provider:** May be at home or different location

Key Question:
What information do you need to make a diagnosis or formulate a care plan?

What is (or not) appropriate for telemedicine?

GOOD USE CASES

- Follow-up of chronic conditions such as mental health concerns, HTN, DM, obesity and COPD
- Discussion of test results (labs, imaging)
- Counseling about diagnostic and therapeutic options
- New or established patients with skin conditions

NOT SO GOOD USE CASES

- Anything requiring a procedure
- Abdominal pain
- Eye complaints
- Gynecologic complaints
- Highly nuanced care or multiple complex problems
- Any situation in which the physical exam would change your recommendation or treatment plan

Consent and Documentation

Example: Language for Telemedicine's risks and benefits

"I cannot provide the same evaluation as in a face to face visit. I may need you to come in for further evaluation or care."

"The technology is encrypted and secure; however, no technology is 100% hack-proof. In addition, the technology is dependent on a reliable Internet connection."

"If at any time you would like to be seen in-person, we will terminate the visit and connect you to the most feasible in-person care."

Example: Telemedicine Dot Phrase

Distant Site Telemedicine Encounter

*I conducted this encounter from {entity name} via secure, live, face-to-face video conference with the patient. {Patient name} was located at *** with {enter who was present with the patient}. Prior to the interview, the risks and benefits of telemedicine were discussed with the patient and verbal consent was obtained.*

Documentation (con't)

- Document as you normally would (HPI, etc). Additionally, I recommend stating start and stop times.
- Physical exam: enter any patient reported vitals (temp, wt, HR/BP, SpO2) and fact that patient was assisting in exam.
- Example of an abd complaint PE:
  - Cons: well appearing, no apparent distress
  - Eyes: conj clear w/o icterus, pallor or injection
  - ENT: nose w/o external redness or drainage, OP clear w/ good dentition, MMM.
  - CV: no LE edema or cyanosis
  - Resp: nl WoB, no audible wheezing
  - GI: flat, non-distended, NT to self-palpation
  - Skin: no spider angiomata, no lesions
  - Heme/Lymph: pt palpated no SM, SC or axillary LAD, no ecchymoses
  - Endo: no acanthosis nigricans
  - MHE: linear thought process, euthymic, nl rate and vol speech
  - Neuro: alert and oriented, no flap or tremors. Moving UE appropriately.

Level 3 99203: 2-7 organ systems, Level 4 99204: 8 or more organ systems

Billing

- For Telehealth, you can bill on TOTAL time, including review of outside records, actual time with patient and documentation. “I spent 32 minutes on this visit today including chart review prior to the visit, face to face time with the patient, and documentation and coordination of care after the visit." Bill 99214 for outpt f/u.
- Can also bill based on medical decision-making
- Use the GT modifier for video visits only
- Facility fee code: Q3014
- For duration of public health emergency, phone visits will pay at same rate as telehealth and in-person visits

Code	Time
99213	15 min
99214	25 min
99215	40 min
99203	30 min
99204	45 min
99205	60 min
Phone	
99441	5-10
99442	11-20
99443	21-30

For more info: https://www.americantelemed.org/policy/covid-19/

Visit Logistics

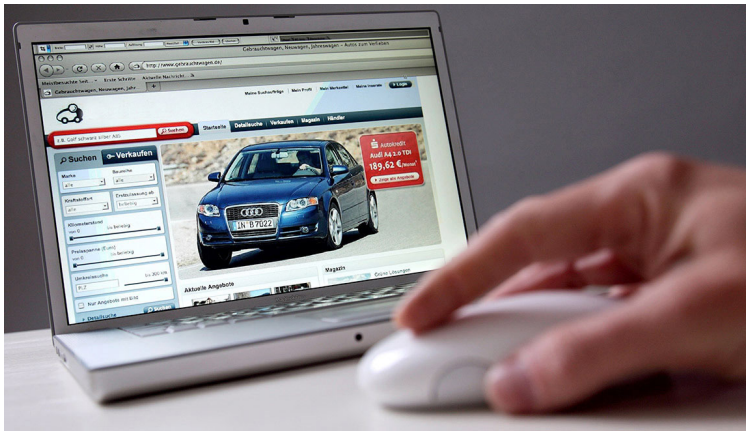
- Good environment
  - Front lighting, quiet, consider what's in your bkgd
- Introduce yourself/show badge/scan room
- Camera placement
  - Eye level
- Professional clothing
- Do NOT record!!!

Which background is preferable?

What's important in technology?

- Ease of use
- Reliability
- Security/privacy
- Cost
- Function in low bandwidth situations
- EMR integration
- Screen share function

- Multipoint connections
- Mobile app
- Other uses/applications



Please check out Telehealth Technology Assessment Resource Center (TTAC):
https://www.telehealthresourcecenter.org/ttac/?Center=TTAC

Other tips and suggestions

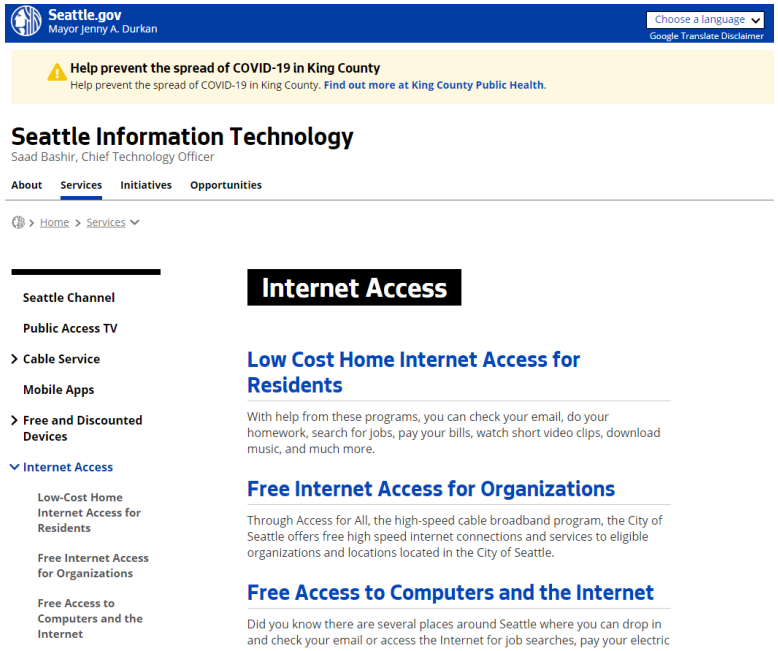
- Don’t overspend on technology!
- Try to use as few vendors and platforms as possible, leverage what you have, ask for improvements
- Don’t get locked into long-term contracts
- Does your EMR offer good enough technology?
- How good is the vendor with relationship (ask around)?

Technical Requirements for Providers

- Internet Speed: You need at least 1.2 mbps upload/download speed if using a laptop and 600 kbps if using a mobile device. Please do a speed test by going here: https://www.speedtest.net/.
- Device: If using a PC, you should have at 2GHz processor with 4GB of RAM. A mobile device should have a 1 GHz processor. Your device should have a screen that is large enough to allow you to clearly view the patient.
- Device Set Up & Configuration: Ideally, you would have two monitors connected to either a desktop or laptop. One screen to display video of patient, the other for the EMR.
  - If dual screens are not possible, a 21”-23” screen which would allow for both video and EMR on same screen.
  - Otherwise, a standard sized screen by itself or paired with a mobile device running video can be used. Larger screen is preferred.

Working in low bandwidth, low tech access settings

- There are many new programs for low cost or free devices and broadband during COVID19
  - Local government, Medicaid, Internet service providers
- Many students have received tablets and laptops for schoolwork, could they be used for a video visit?
- Kiosk or hub and spoke model
- Piggyback on other infrastructure



https://www.seattle.gov/tech/services/internet-access; https://www.phila.gov/2020-03-25-staying-connected-during-covid-19/

Digital Divide is Real

There are three overlapping barriers: digital literacy, absence of technology, and reliable Internet connectivity. These barriers are superimposed on pre-existing health inequities.

- People of color and limited English proficiency have shorter visits
- Providers have more anxiety about interacting with patients of color
- Providers commit microaggressions towards patients
- Seeing patient's home environment is known to trigger inaccurate stereotypes, prime implicit biases, and affect provider behavior
- We need to acknowledge, reach out to communities of color and LEP and work towards common solutions

Velasquez and Mehrotra (Health Affairs Blog, May 5, 2020)

References

- Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.* Washington, DC: National Academy Press, 2002.
- Zestcott CA, Blair IV, Stone J. Examining the presence, consequences, and reduction of implicit bias in health care: A narrative review. *Gr Process Intergr Relations*. 2016;19(4):528–542.
- Cooper LA, Roter DL, Carson KA, et al. The associations of clinicians' implicit attitudes about race with medical visit communication and patient ratings of interpersonal care. *Am J Public Health*. 2012;102(5):979–987.
- Hagiwara N, Penner LA, Gonzalez R, et al. Racial attitudes, physician-patient talk time ratio, and adherence in racially discordant medical interactions. *Soc Sci Med*. 2013;87:123–131.
- Hagiwara N, Dovidio JF, Eggly S, et al. The effects of racial attitudes on affect and engagement in racially discordant medical interactions between non-Black physicians and Black patients. *Gr Process Intergr Relations*. 2016;19(4):509–527.
- Hagiwara N, Slatcher RB, Eggly S, et al. Physician racial bias and word use during racially discordant medical interactions. *Health Commun*. 2017;32(4):401–408.
- Cruz D, Rodriguez Y, Mastropaolo C. Perceived microaggressions in health care: A measurement study. *PloS one*. 2019;14(2):e0211620.
- Almond AL. Measuring racial microaggression in medical practice. *Ethnicity & Health*. 2017;24(6): 589–606.
- Williams MT, Gooden AM, Davies D. African Americans, European Americans, and pathological stereotypes: An African-centered perspective. In Hayes GR, Bryant MH, eds. Psychology of Culture. Hauppauge, NY: Nova Science; 2012:25–46.
- Van Ryn M, Burke J. The effect of patient race and socio-economic status on physicians' perceptions of patients. Soc Sci Med. 2000;50(6):813–828.

QUESTIONS?