PHYSICIAN INNOVATION NETWORK

Telemedicine amid COVID-19

Virtual Panel Discussion

March 23 – April 17, 2020

Discussion Transcript

AMA | Physician Innovation Network

Telemedicine amid COVID-19

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EXECUTIVE SUMMARY

This virtual conversation covered many aspects of telemedicine as it was being rapidly deployed during the COVID-19 public health emergency. Experts from across the industry convened to answer questions and share expertise and best practices from their own experiences. Key themes and findings identified in this discussion include:

- Interest in the expansion of coverage for telemedicine and licensure across states and the expedition of the licensing process, as well as how organizations are supporting streamlined credentialing to quickly leverage additional resources. Physicians agreed that state licensure boundaries create actual care boundaries.
- The conversation highlighted the notion that despite the quick implementation of telemedicine, there is still a need to protect data privacy.
- Asynchronous modes of telemedicine such as digital check ins and remote patient monitoring and the key role they play for COVID-19 were discussed, along with how to manage chronic and low risk conditions, and preventative care amid this pandemic.
- Questions around reimbursement and coding for telemedicine were common, and the AMA's Advocacy team worked tirelessly to provide answers.
- Best practices relating to the implementation of telemedicine were addressed, including ensuring that all patients are educated and comfortable with the technology with which they will be communicating with their care providers, how to complete a telehealth visit (including preparation), and how to tell patients about telemedicine offerings.
- Medical students showed pointed interest in getting involved in telemedicine to address COVID-19 and various companies and stakeholders provided suggestions on how they could get engaged, including involvement in student run biotech incubator Sling Health and our co-built Clinical Problem Database, as well as specific companies that chimed in with opportunities for medical student involvement.
- Throughout the discussion, it became clear that there are gaps in patient-facing information and education on telehealth. Also identified were gaps in accessibility, equity, regarding telehealth and COVID-19 data.
- There was also interest in the future of telemedicine post-COVID and how to address a potential regression.

Overall, the conversation was engaging and educational, covering many aspects of telemedicine and the impact of COVID-19. **A special thank you to all our panelists and those who participated!**

EXPERTS

Russell Libby, MD

Russell Libby, MD, board member of the Physicians Foundation, is the founder and president of Virginia Pediatric Group, a primary care pediatric practice in Northern Virginia, and co-founder of American Pediatric Consultants, a pediatric home care company. He is a delegate to the AMA representing the Integrated Physician Practice Section. He is a founder of Health Connect IPA, a primary care Independent Practice Association. He is chief of general pediatrics at Inova Children's Hospital. Dr. Libby has served as president of the Medical Society of Virginia and the Medical Society of Northern Virginia (MSNVA). His work at the American Academy of Pediatrics includes their textbook, "Guidelines for Pediatric Home Health Care," and participating in policy development through his terms on various committees and sections. Dr. Libby has extensive legislative experience representing organized medicine, especially on issues pertaining to malpractice liability reform, the business of physician practice, and the patient-physician relationship. He was a founding member of the Aetna Physician Advisory Board where he represented plaintiff physicians from the class action settlement which also created the Physicians Foundation where he is actively involved, leading their efforts on physician well-being and telemedicine. Dr. Libby earned his medical degree from George Washington University.

Sylvia Romm, MD

Sylvia Romm, MD, MPH, is driven by a passion for transforming health care delivery to patients and communities. She brings her background and expertise as a clinician and an entrepreneur to her role as Chief Innovation Officer for Atlantic Health System. Firmly believing that a patient-centered focus is vital to health care innovation, Dr. Romm works with Atlantic Health System's team members and physicians to find new ways to improve access to high-quality, affordable care. She also forges relationships with local and national innovation partners and works to expand our organization's research profile. Dr. Romm is an avid author and speaker in the areas of health care, technology and health information technology (IT) policy. She has written articles for various publications, including NEJM Catalyst, Forbes, KevinMD, and the Huffington Post, and was named one of FierceHealthCare's 8 Influential Women Reshaping Health IT and Becker's Women in Health IT to Watch in 2020. A board-certified pediatrician, Dr. Romm has served in a variety of clinical leadership roles throughout her residency and as a hospitalist. Before joining Atlantic Health System, she was Vice President of Clinical Transformation for American Well, the largest video-based telemedicine company in the United States. In addition, she was the founder of Sonder Health (formerly MilkOnTap), the nation's first telehealth company focused on the needs of nursing mothers and lactation support. Dr. Romm earned her Master of Public Health in Global Health from Harvard TH Chan School of Public Health. She holds a medical degree from the University of Arizona College of Medicine and completed her residency in pediatrics at Massachusetts General Hospital.

Sandy Marks

Sandy Marks is Senior Assistant Director of Federal Affairs in the American Medical Association's Washington office. She is part of the AMA team advocating for needed federal policy changes to respond to the novel coronavirus pandemic. Sandy is also responsible for advocating AMA positions on Medicare physician payment policy, with a particular focus on alternative payment models, and played a key role in the AMA's successful campaign to eliminate the Sustainable Growth Rate formula. She contributed to the AMA's joint paper with the Center for Healthcare Quality and Payment Reform, "A Guide to Physician-Focused Alternative Payment Models," and organized AMA workshops for physicians on alternative payment models. She also handles federal advocacy on efforts to combat the opioid epidemic and other public policy issues, as well as liaison with federal agencies. Sandy has an MBA from the Kellogg School of Management at Northwestern University and began her professional career as a health policy research analyst at Northwestern.

Sherry Smith, MS, CPA

Sherry Smith is the Director of Physician Payment Policy and Systems at the American Medical Association. She is a national expert on the Resource-Based Relative Value Scale (RBRVS), which is the system used to distribute fee-for-service payment to health care professionals by Medicare and other payers. Sherry and her team staff the AMA/Specialty Society RVS Update Committee (RUC), The RUC was established by the AMA and national medical societies in 1991. The RUC submits recommendations to the Centers for Medicare and Medicaid Services regarding the resources utilized in the provision of physician services. Prior to her career at the AMA, Ms. Smith was employed by the University of Chicago Hospitals and Blue Cross and Blue Shield of Illinois, with a focus on Medicare hospital payment policy. Ms. Smith obtained her Master of Science degree in Health Policy and Administration at the University of Illinois and her Bachelor of Business degree in Accounting from Western Illinois University. She is a certified public accountant.

Kimberly Horvath, JD

Kimberly Horvath, JD is a senior legislative attorney in the Advocacy Resource Center at the American Medical Association where she leads multifaceted advocacy campaigns across the 50 states on top level healthcare issues, including scope of practice, medical liability reform, physician-led team based care, physician licensure, workforce, telemedicine and truth in advertising. Kim works in strong collaboration with the 50 state medical associations and national medical specialty associations across the country to help shape and inform state laws, regulations and policies in support of patients and physicians. Kim has advocated before national policy making organizations, state legislatures and state regulators.

Raj Ratwani, PhD

Dr. Ratwani is the director of the MedStar Health National Center for Human Factors in Healthcare, part of the MedStar Institute for Innovation. He is also an assistant professor of emergency medicine at the Georgetown University School of Medicine. His career is focused on improving the safety, efficiency, and quality of care through the application of human factors and applied psychology. He has extensive expertise in health information technology usability and safety and has worked to improve this technology for frontline clinicians. He has also worked to optimize healthcare policies to promote safe and innovative technology and testified in front of the U.S. Senate Health, Education, Labor and Pensions Committee on electronic health record usability and safety.

Dr. Ratwani has authored over 50 peer-reviewed journal publications and has been invited to give numerous talks in the area of human factors, health information technology, and safety. His work has been funded by the Agency for Healthcare Research and Quality (AHRQ), the National Institutes of Health (NIH), The Pew Charitable Trusts, and several other agencies and foundations. He holds a master's degree and PhD in psychology, with a focus on human factors, and was a National Research Council postdoctoral fellow at the U.S. Naval Research Laboratory.

Shannon Vogel

Shannon Vogel, Director of Health Information Technology & Special Projects, has been at the Texas Medical Association (TMA) since 1999. In her role, she oversees HIT advocacy, education, and resources for Texas physicians. In addition, Shannon oversees TMA's vendor program that offers discounts to TMA members on a variety of products and services. Shannon is a Health Information Management Systems Society (HIMSS) fellow and serves on the board of the Austin chapter. She received her bachelor's degree from St. Edward's University in Austin and master's degree in health informatics from the School of Biomedical Informatics at The University of Texas Health Science Center at Houston.

Shabana Khan, MD

Dr. Khan has a decade of experience in telemedicine. She is an Assistant Professor and the Director of Telemedicine for the Department of Child and Adolescent Psychiatry at NYU Langone Health in New York City. She is an expert in undergraduate and graduate medical education and training in telemedicine and has extensive experience in the clinical, legal, regulatory, and administrative aspects of telemedicine.

Dr. Khan is Co-Chair of the American Academy of Child and Adolescent Psychiatry (AACAP) Telepsychiatry Committee, member of the American Psychiatric Association (APA) Telepsychiatry Committee, and Co-Chair of the NYU Langone Virtual Health Clinical Workgroup.
Through her active involvement and collaboration with the APA, American Telemedicine Association (ATA), AACAP, and Center for Telehealth and e-Health Law (CTeL), Dr. Khan has helped inform telemedicine legislation, policy, and regulations at the local, state, and national level.

Dr. Khan received a B.A. in Neuroscience from Barnard College and an M.D. from SUNY Downstate College of Medicine. She completed general adult psychiatry residency and child and adolescent psychiatry fellowship at Western Psychiatric Hospital of the University of Pittsburgh Medical Center (UPMC). Dr. Khan is board-certified in General Psychiatry and in Child and Adolescent Psychiatry. She is a Fellow of the American Psychiatric Association (FAPA).

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC

Ezequiel "Zeke" Silva III, MD, FACR, FSIR, FRBMA, RCC, is Co-Chair of the American Medical Association's Digital Medicine Payment Advisory Group (DMPAG), a member of the AMA/Specialty Society RVS Update Committee (RUC) and Chairman of the RUC Research Subcommittee. He is a member of the American College of Radiology (ACR) Board of Chancellors and the chairman of the ACR Commission on Economics. He is a founding board member of the Neiman Health Policy Institute. He recently served as Co-Chair of two CMS Acumen Clinical Subcommittees. One on Peripheral Vascular Disease and the other on Hemodialysis Access Creation.
Dr. Silva has approximately 70 peer-reviewed publications and book chapters, as well as over 50 CME approved scientific lectures and exhibits to his credit. These are largely focused on payment policy, quality initiatives and digital medicine applications in health care. As lead author, Dr. Silva's 2016 paper on alternative payment models was awarded the "Best of 2016" by the Journal of the American College of Radiology.

In San Antonio, Dr. Silva is the Medical Director of Radiology at both the Methodist Texsan Hosptial and the Methodist Ambulatory & Surgical Hospital. He is an adjunct professor at UT Health - San Antonio.

Ethan Bechtel

Ethan Bechtel is the CEO and co-founder of OhMD, a HIPAA compliant texting and telehealth platform that combines two-way SMS texting with video visit functionality. Ethan and his team are focused on humanizing healthcare communication using technology for during visits and between visits. He previously spend 10 years building a health-tech consultancy, MBA HealthGroup, with his brother and OhMD co-founder, Nate Bechtel. MBA HealthGroup delivered implementation, integration, and support services for large implementations of electronic health records (EHRs).

Emily Carroll, JD

As a Senior Legislative Attorney for the American Medical Association’s Advocacy Resource Center, Emily provides legislative and legal support to state and national medical specialty societies on private payer practices and health insurance reforms. Prior to joining the AMA, Emily worked as the Legislative Director at the law firm Powers, Pyles, Sutter and Verville, P.C. in Washington, D.C., representing health care, disability and employment provider organizations. She received her law degree from Chicago Kent College of Law, a Master of Social Work degree and Certificate in Health Care Administration and Policy from the University of Chicago, and her undergraduate degree from the University of Michigan.

Annalia Michelman

Senior legislative attorney, AMA
• AMA Economic Impact Study • Health disparities and LGBT issues • Medicaid/CHIP • Patient-physician relationship issues • Physician business issues • Program integrity • Public health improvement • Public safety • State budget issues/provider taxes

Jamey Edwards

As the CEO of Cloudbreak Health ("Cloudbreak"), Jamey is on a mission to #HumanizeHealthcare. Cloudbreak is a healthcare solutions innovator delivering over 1 million telemedicine encounters per year to over 1,200 healthcare facilities nationwide over Cloudbreak Connect, a private path broadband network optimized for secure and high-quality healthcare collaboration. It's novel approach to unified telemedicine has been recognized with a Patrick Soon Shiong Innovation Award and the Company acknowledged as one of the top entrepreneurial companies (#25) in the nation by Entrepreneur Magazine and as a finalist for the E&Y Entrepreneur of the Year Awards. Cloudbreak's has also been recognized as a best video conferencing solution and best overall medtech software by MedTech Breakthrough and as a finalist in the telemedicine category for the UCSF Digital Health Awards.

Prior to Co-founding Cloudbreak, Jamey was the CEO of Emergent Medical Associates (www.ema.us), a multi-specialty medical group in the Southwest providing ER, Hospitalist and Anesthesia services. During his tenure at EMA, EMA grew into an industry leader serving almost 1 million patients per year at over 40 programs in multiple states. EMA was honored as a 4x Inc. 500 | 5000 Company, a 2x finalist for Ernst & Young Entrepreneur of the Year & named 2x to Modern Healthcare Hottest companies list. He remains with EMA as a Board Member responsible for M&A and strategy.

Prior to EMA, he was a member of the Investment Banking Division of Lehman Brothers. Based in New York, he consummated transactions totaling more than $8 billion for leading companies including dj Orthopedics, InterActive Corp, Greenfield Online, Premier Retail Networks, Six Flags, Viasystems, YouBet.com, Sirius Satellite Radio and Google. While at Lehman, he served as captain of the Cornell Recruiting Team and on the firm's Global Advisory Council.

Prior to joining Lehman Brothers, Mr. Edwards served as a Fund Manager for BR Venture Fund (www.brventurefund.com), the seed stage venture capital fund for Cornell University. Before BR Venture Fund, Mr. Edwards was the Director of Business Development for VirtualTourist.com (www.virtualtourist.com), an award winning online travel community solution provider and leader in collaborative social networking and user generated content. Prior to VirtualTourist, Mr. Edwards was an Associate with Caltius Mezzanine Partners where he evaluated potential investment opportunities, and an Analyst with U.S. Bancorp Libra, a boutique investment bank focused on the middle market.

Mr. Edwards has been a speaker for the Healthcare Information and Management Systems Society (HIMSS) conference, National Association of Seed and Venture Funds, Entrepreneurship @ Cornell, the Southwest Telemedicine Resource Center, the AICPA and the Connect. Communicate. Care. Conference.

Jamey is a Health Transformer for Startup Health, one of the leading healthcare incubator/accelerator's in the country and was recognized as one of the top 40 health transformers nationwide by MM&M Magazine. He also was recognized as a Change Maker nationally by HIMSS in 2019. He is a proud member of the #pinksocks tribe of innovators looking to improve our nations healthcare system (www.pinksocks.life).

Mr. Edwards graduated a Tradition Fellow from Cornell University in 1996 and received his MBA from Cornell's Johnson Graduate School of Management in 2003. He is a member of the Cornell University Council and is also an alumni of the Design Thinking Bootcamp at Stanford University's d.school.

Mr. Edwards is currently Chapter Chair of the Santa Monica Bay Chapter of YPO and serves on the board of the American Red Cross of Los Angeles and the Partners in Care Foundation as well as on the Executive Leadership Team for the American Heart Association. Mr. Edwards is also an angel investor and mentor to startup companies, a co-founder of Noll Surfboards (www.nollsurfboards.com) and a Principal with Avanti Hospitals, LLC (www.avantihospitals.com).

Joseph Kvedar, MD

Dr. Joe Kvedar is creating a new model of health care delivery, moving care from the hospital or doctor's office into the day-to-day lives of patients. He is the author of two books on the subject: *The New Mobile Age: How Technology Will Extend the Healthspan and Optimize the Lifespan* (2017) and *The Internet of Healthy Things* (2015).

At Partners HealthCare, Dr. Kvedar is leveraging personal health technologies to improve care delivery and help providers and patients better manage chronic conditions, maintain health and wellness and improve adherence, engagement and clinical outcomes. He has launched a number of innovative health tracking programs, mobile health, virtual care initiatives and clinical research programs for the more than 1.5 million patients served at Partners HealthCare-affiliated hospitals, including Brigham and Women's Hospital and Massachusetts General Hospital.

Dr. Kvedar serves as Program Chair for the Connected Health Conference, an industry defining event co-hosted by Partners Connected Health and the HIMSS Personal Connected Health Alliance (PCHAlliance). He is also a member of the PCHAlliance Board of Managers.

Internationally recognized for his leadership and vision in the field of connected health, he currently serves on the Editorial Board of *npj Digital Medicine*, a *Nature* Research journal. The cHealth Blog provides his insights and vision for connected health. Dr. Kvedar serves as a strategic advisor at Flare Capital Partners, Wave Edge Capital, PureTech Ventures and Qualcomm Life; he is also a member of the board of b.well Connected Health. He is co-chair of the American Medical Association's Digital Medicine Payment Advisory Group; and a member of the Board of Xcertia, a collaboration between AHA, AMA, DHX Group and HIMSS dedicated to improving the quality, safety, and effectiveness of mobile health applications (apps). Dr. Kvedar is a professor of dermatology at Harvard Medical School.

Frederick Browne, MD

Residency trained at Pennsylvania State University/Hershey Medical Center in Hershey, PA in Internal Medicine and Anatomic/Clinical Pathology. Fellowship trained at Yale University School of Medicine in New Haven, CT in Infectious Diseases, Medical Microbiology and Epidemiology with board eligibility in Medical Microbiology and board certification in Internal Medicine and Infectious Diseases. He has been awarded professional fellowships in the Society of Healthcare Epidemiology of America and American College of Physicians. His clinical training has led to two academic appointments at Quinnipiac University Frank Netter MD School of Medicine, North Haven, CT where he is an Associate Clinical Professor of Medicine and Sacred Heart University, Fairfield, CT where he teaches the Masters in Physician Assistant Studies Clinical Microbiology/Infectious Diseases course to share his knowledge and keep up with the recent developments in his clinical field of expertise.

Dr. Browne is also a graduate of the University of New Haven, West Haven, CT where he received a Masters of Business Administration and is currently a student at Thomas Jefferson University, College of Population Health, Philadelphia, PA where he will receive a certificate in Population Health in January 2018.

After finishing his fellowship Dr. Browne started his own private practice in Infectious Diseases at New Milford Hospital, New Milford, CT and began to take on administrative roles including oversight of Hospital Epidemiology and Microbiology as well as numerous hospital committees. As he came to completion of his Masters in Business Administration he had already expanded his hospital operational roles to include management of the medical staff office, physician quality including peer review, pharmacy and the employed medical group. While at New Milford Hospital Dr. Browne was promoted to Director of Medical Affairs and then Vice President of Medical Affairs/Chief Medical Officer. In 2011 he was named one of Modern HealthCare's Up and Comers. He transitioned to South County Hospital, Wakefield, RI where he held a similar role as the Vice President of Medical affairs/ Chief Medical Officer with operational responsibility over the Medical Staff Office, Quality, Risk, Laboratory, Radiology and the employed medical group. In 2014 he returned to Connecticut to join the executive team at Griffin Hospital where he remains the Vice President of Medical Affairs/ Chief Medical Officer and focuses the majority of his time on the clinical population health strategy.

Dr. Browne has been a diverse and active investor his entire life. With his extensive experience as a Vice President of Medical Affairs, Chief Medical Officer, Academian and Clinician he now has developed a great passion for learning and educating fellow clinicians about alternative investing in private equity companies. He has also personally invested in and advises private equity companies.

Joy Lee, PhD

Dr. Joy Lee is a health services researcher using mixed methods to examine how patients and providers communicate with each other electronically. In addition to electronic patient-provider communication, she has special research interests in improving chronic disease management, evaluating medication safety, social media and health, and the patient-provider relationship through various electronic communication channels including video blogs.

Dr. Lee obtained her master's degree in health policy and management in the Harvard T. Chan School of Public Health and doctoral degree in health services research and policy from the Johns Hopkins Bloomberg School of Public Health, where she also completed a post-doctoral fellowship in health services research and policy. Dr. Lee holds an adjunct faculty appointment in the Department of Health Policy and Management in the Richard M. Fairbanks School of Public Health.

Lisa Sanders, MD

Lisa Sanders is an internist on the faculty of Yale School of Medicine and teaches in the Internal Medicine residency program there. She graduated from Yale Medical School and did her residency and chief residency at Yale's Internal Medicine Primary Care Residency Program. Sanders created and writes the biweekly Diagnosis column for the New York Times Magazine. Her column was the inspiration for the hit television series House MD and she was an advisor for the show. Working with the New York Times and producer Scott Rudin, Sanders helped create a series of documentaries which followed patients in their search for a diagnosis using crowdsourcing. These documentaries are airing on Netflix. Her most recent book, Diagnosis: Solving the Most Baffling Medical Mysteries, a collection of her New York Times columns was published this summer. She also wrote the New York Times best seller, Every Patient Tells a Story: Medical Mysteries and the Art of Diagnosis. Before Sanders came to medical school she was an Emmy award winning producer for CBS News. She lives in New Haven, CT with her husband, award-winning writer and radio personality, Jack Hitt.

Michael Weiner, MD, MPH

Michael Weiner, M.D., M.P.H. is Principal Investigator of the Department of Veterans Affairs Health Services Research & Development Center for Health Information and Communication, Professor of Medicine at the Indiana University School of Medicine, and Associate Director of Regenstrief Institute's William M. Tierney Center for Health Services Research, in Indianapolis. His clinical and health-services research focuses on measuring and improving the quality, coordination, and delivery of health services, especially for older adults. He studies the effects of health information and information technology on behaviors, clinicians' practices, and patients' outcomes. He has conducted studies of specialty referral, patient-physician videoconferencing, and other forms of telecommunication to improve health care. Study methods have included cohort studies, clinical trials, surveys, and focus groups. Current research includes the development, implementation, and study of information systems to promote clinical handoffs, management of medications, patient-centered care, health information exchange, and clinical decision support.

Jennifer McWilliams, MD, MS, DFAACAP

Dr. Jennifer McWilliams is a child and adolescent psychiatrist and the Clinical Service Chief in the Department of Behavioral Health at Children's Hospital and Medical Center in Omaha, Nebraska, where she has worked since 2015. She attended medical school at the University of Nebraska Medical Center and completed her residency and fellowship at the University of Iowa Hospitals and Clinics. She has a Master's degree in Health Care Delivery Science from Dartmouth. She has seen patients in rural Nebraska and Iowa for the past ten years using telemedicine technology and currently sees 90 percent of her patients via telemedicine. She serves on the Telepsychiatry Committee for the American Academy of Child and Adolescent Psychiatry.

Ujjwal Ramtekkar, MD, MPE, MBA

Dr. Ujjwal Ramtekkar is a child and adolescent psychiatrist at the department of Psychiatry and Behavioral Health at Nationwide Children's Hospital and assistant clinical professor at the Ohio State University. He serves as associate medical director for Partners for Kids, one of the largest pediatric accountable health organization, with focus on pediatric behavioral health initiatives. His current work focuses on novel methods of healthcare delivery including telehealth, integrated and collaborative care models for rural and underserved areas in child health, leading Project ECHO for behavioral health, autism and integrated care expansion. He is a member of the Telepsychiatry Committee and Committee on Quality Improvement for the American Academy of Child and Adolescent Psychiatry and contributed to publications including practice guidelines for telepsychiatry.

Amy Sheon

Amy have a 30+ year career focused on emerging public health crises from COVID-19 to childhood obesity and HIV. Understanding social determinants of health and addressing health disparities are in my DNA. Through the National Digital Inclusion Alliance, where Amy is a Senior Fellow, she focuses on identifying and addressing patient barriers to use of digital health tools such as telehealth and patient portals. Through Public Health Innovators, LLC, she brings public health perspectives to health innovation, and innovation to public health processes. She created DESCAR, the Digital Equipment, Skills and Connectivity Assessment and Referral tool for health systems to facilitate patient access to telehealth and digital medicine. As a member of the NODE.Health Executive Board, she encourages consideration of disadvantaged patients' needs with regard to digital medicine. At Case Western Reserve University School of Medicine, she directs the Urban Health Initiative and co-developed a virtual reality training application to improve care and empathy around the social determinants of health: https://equityvrtraining.org/#simulations.

Amy worked at NIAID/NIH in Epidemiology, Prevention and Vaccine Trials in the earliest days of the AIDS epidemic, developing considerable insight into the rapidly unfolding COVID-19 epidemic.

DISCUSSION QUESTOINS & REPLIES

Is there a video component or is this a text-based chat only?

Lisa Fitzpatrick, MD, MPH, MPA

Replies

Celine Witherell, AMA

Hi Dr. Fitzpatrick, Thanks so much for reaching out. The discussion is all online and asynchronous in a text format to accommodate panelists' and participants' busy schedules. We don't currently have a video component but we will keep you posted. Thank you for your participation! Let me know if you need anything else. Best, Celine

RUSSELL LIBBY, MD (Expert)

There is a lot to evolve and we are just starting to tread into this sort of exchange with a platform that will adapt to the needs of its users. One might think that a telemedicine discussion platform would use video. I hope we can develop areas of interest that might be specific to the individual. Please stay engaged and contribute! Thanks

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Will remote patient monitoring be included in this discussion today?

William Paschall

Replies

Celine Witherell, AMA

Hi William, This is a very open discussion and as RPM is a delivery method of telemedicine, we encourage you to ask questions about RPM as it relates to COVID-19 and telehealth and our panelists will answer as best and quickly as possible. Let me know if you need anything else, thanks! Best, Celine

Michael Weiner, MD, MPH (Expert)

With COVID-19, low-tech solutions can often be a great help. For example, with home-quarantined patients, a telephone and a thermometer, combined with daily follow-up using them, may be sufficient to determine whether a patient is deteriorating. The bigger need in these cases is sometimes a systematic and rigorous approach to tracking the cases comprehensively, so that no one is left without the proper follow-up. That requires a robust information system rather than just a device.

Stacy Lloyd, MPH

Hi William - RPM is definitely a part of this discussion. We've included the appropriate codes for RPM services in the Telemedicine Quick Guide: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice . And you can also access the Digital Health Implementation Playbook focused on RPM that was released in 2018 here: www.ama-assn.org/digital-health-playbook !

While the COVID-19 pandemic has been a catalyst for telemedicine, how important is it maintain regulatory safeguards for data privacy?

Sandeep Pulim, MD

In his article "Why Telehealth Champions Are Worried About Trust" David Shaywitz discussed key questions related to the need for "rapid execution and good data privacy rights" at a time of crisis. https://timmermanreport.com/2020/03/why-telehealth-champions-are-worried-about-trust/

Replies

William Paschall

Apparently not very, as HIPAA requirements are waived https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.

Lindsey Williams

Impact of HIPAA Requirements on Legal Liability

While the government has waived these requirements, will Physicians and patients feel comfortable risking their data? And will physicians be released of all legal liability should a patient information breach occur?

Shannon Vogel (Expert)

OCR's relaxation of the regulations during the COVID-19 emergency primarily extends to the platforms clinicians use for a telehealth visit. For example, technology tools such as FaceTime and Skype are temporarily permitted even though this technology is not encrypted nor HIPAA compliant. Physicians should continue to document the patient visit within the EHR and apply the same standard of care as though the visit happened in person. There is no reason for PHI to be stored via the unsecure communication tools.

> *Lindsey Williams*
>
> What about the ability for some of these platforms (like Webex, zoom, etc.) too record and store data on their servers? Documentation may not take place on the platform but if the information is recorded somehow its still a vulnerability, correct?

Shannon Vogel (Expert)

@LindseyWilliams, that is an excellent point. I'm not familiar enough with all of the platform capabilities, but visits should not be recorded and saved.

Shall we visit some of the basics?

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

1/ I expect that this discussion will become quite detailed as it evolves. Starting with some basics by discussing the recent

changes affecting Telehealth amid the Covid-19 crisis. We are all learning together, so please correct or add to any of the points I make. The Coronavirus Preparedness and Response Supplemental Appropriations Act was signed into law on March 6, 2020 and remains in effect until the Covid-19 Public Health Emergency (PHE) ends. Significant changes from the law include: (1) Where patients may receive telehealth services; (2) how physicians/qualified health providers (QHPs) are paid for these services; (3) what technology may be used for in providing telehealth services; and (4) HIPPA enforcement during the crisis. I notice topic #4 is part of a parallel discussion string, so I will discuss the first three. (1) Where patients may receive services: Previously, only routine visits in certain circumstances, such as rural areas, were covered. Even there, beneficiaries were required to travel to a local medical facility to receive services from a remote facility. Care from the home was not allowed. The term used for the location of the patient is "eligible originating site". Under the Coronavirus Act, beneficiaries may receive telehealth services in any healthcare facility, even their homes. This includes office visits, mental health screenings, and preventive health screenings. The broader goal is to keep at-risk patients safe in their homes while maintaining access to care.

Replies

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

2/ (2)How physicians / QHPs are paid: These changes apply only to the Medicare program. Private payors may enact similar provisions but that will vary and is not immediate. These telehealth services will be paid under the Medicare Physician Fee Schedule and at the same amount as in-person services. For instance, an office E/M service could be provided by telehealth in the home and paid at face-to-face payment rates. Medicare coinsurance and co-pay still apply. This applies to all patients, not just those affected by the virus. When billing for these services, the Place of Service code is: 02-Telehealth. No billing modifiers are required. If there is a difference in the fee schedule between physician office and facility payment, the facility payment is applied. The established patient requirements are waived. In other words, during this emergency, it is not required that the patient have a prior relationship with the patient. These changes only apply to physicians / QHPs, not facilities which bill from other fee schedules such as the OPPS or IPPS. But facilities may be able to bill the originating site facility fee. It is also worth noting that there are several other recently enacted telehealth services which are available such as virtual check-ins, online digital visits, remote patient monitoring, telephone evaluation and management and remote consultations.

> *Sandy Marks (Expert)*
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> Medicare Cost-Sharing
>
> Thanks for synopsis of the recent policy changes! Wanted to note that per OIG the cost-sharing may be waived. This is from CMS' new telehealth fact sheet: "The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs."

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

3/ (3) Which technology may be used: A wide range of communication tools, including telephones with video and audio capabilities may be used. Others include mobile computing devices capable of two-way, real time interactive communication, such as Skype. Straight audio communications, such as a simple telephone are not included.

> *Sherry Smith, MS, CPA (Expert)*
>
> Telephone calls
>
> The AMA is working hard to persuade CMS and commercial insurers to also include audio only communications (telephone calls) during this public health crisis.

Michael Weiner, MD, MPH (Expert)

Congratulations to the AMA on pursuing approval for audio-only communications. This is a patient-centered approach that will often meet the patient's needs more closely, while still providing valuable information-- sometimes just as good as audio+video in terms of key "lessons learned" about the patient. Even in the 21st century, with a plethora of video tools, I am amazed to see the persistence of so many challenges with video communication and technologies: poor lighting, wifi dropouts, problems with bandwidth and quality of service, bad cameras, inadequate training, and most commonly, inadequate usability of systems.

Sandeep Pulim, MD

CMS Telemedicine Healthcare Provider Fact Sheet

Here is the link to the CMS info... https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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Regarding telemedicine visits, are other payers reimbursing the same codes as CMS?

Sandeep Pulim, MD

I have only been able to find the following resource from AHIP https://www.ahip.org/health-insurance-providers-respond-to-coronavirus-covid-19/ and BCBSA https://www.bcbs.com/coronavirus-updates

Replies

RUSSELL LIBBY, MD (Expert)

Most payers are using the same codes. It is easy enough to test codes through your business office or billing manager. There may be variations on some nuances of billing between commercial insurers.

Shannon Vogel (Expert)

Some payer policies vary by state. In Texas, Governor Abbott directed TDI to issue emergency rules requiring state-regulated plans to pay for telemedicine and telephone visits at the same rate as an in-person visit.

With the new COVID-19-related CMS waivers, do you expect to see clinicians begin to deliver preventative services, like annual wellness visits and advance care planning remotely via telemedicine?

Mitch Evans

Previously, it seems they were restricted to clinic-to-clinic encounters, which limited adoption. Additionally, what do you see as the primary drawbacks to delivering these services using telemedicine?

Replies

RUSSELL LIBBY, MD (Expert)

The issue around payment for preventive care is extremely relevant and may be necessary for the care of patients and the survival of primary care physician practices. Obviously CMS has not deemed it reimbursable nor have any commercial insurers that I know of, but if the situation persists we will have to be creative about providing well care and immunizations. I am appealing to the governor of Va where I practice (pediatrics) to issue an executive order mandating payment for well care.

Joy Lee, PhD (Expert)

Drawbacks

Regarding drawbacks, and thinking longterm-- beyond the fact that certain preventive services (like immunizations, as mentioned above) need to be done in person, patient centeredness and maintaining and measuring quality is always a concern. Especially when it comes to things like advance care planning. Building rapport, assessing understanding, proper consent are all possible via telemedicine, just as they are in-person. But these activities all require some delicate effort and attention to make patients and clinicians comfortable doing this via telemedicine.

> *Mitch Evans*
>
> Thanks, Dr. Lee. Great points about the delicate nature of ACP discussions and the challenge of conveying empathy over a digital medium.
>
> *Michael Weiner, MD, MPH (Expert)*
>
> I agree with Dr. Lee. Aside from the issues about payment, coding, and procedures such as immunizations, the issue of patients' expectations is an interesting one. Many patients have an expectation that an annual assessment will include a physical examination. If they don't get it, they feel "short-changed". Especially with an increasing evidence base that suggests careful targeting of the physical examination, aligning practices with expectations, without providing overuse of services, is especially important. Ideal intervals for most types of general and preventive care are poorly understood and not commonly studied. In addition, whether a remote "annual exam" is medically feasible may depend partly on whether the patient is reporting to the office at other times during the year, when in-person requirements can be met (again, thinking medically and not specifically regarding coding requirements).

Mitch Evans

Thanks for the quick response, Dr. Libby! It sounds like I may be misreading the nature of the 1135 waiver. Would these services fall under the "Medicare Telehealth Visits" category addressed in the recent CMS Fact Sheet (https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet), since they're included in the full list of covered telehealth services linked in the table from the CMS fact sheet (https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes)?

RUSSELL LIBBY, MD (Expert)

If you look at the codes identified they are not preventive care codes. Certainly one can take specific chronic conditions and bill using the listed E&M codes. And I agree with Dr Lee about face to face and hands on care when it is possible.

RUSSELL LIBBY, MD (Expert)

This is a good review and has some links to an xcel list of codes, none of which are preventive care codes
https://www.medicaleconomics.com/news/coronavirus-cms-eases-restrictions-telehealth-and-virtual-

services?rememberme=1&elq_mid=11260&elq_cid=91195&GUID=9DED6344-66C2-4D1D-877E-E73369900692

Telemedicine really was not widely adopted prior to this pandemic. The utilization is now skyrocketing. After this disaster will telemedicine be a viable alternative to face to face visits?

Frederick Browne, MD (Expert)

Replies

RUSSELL LIBBY, MD (Expert)

It should be a routine part of the practice schedule. As a pediatrician, it is a valuable triage tool and I have been using telemedicine for psychopharm f/u's for over a year with great success and patient satisfaction. In my practice area, travel and wait times can be formidable and telemedicine is a blessing for all. I have developed visual templates for a physical exam and a number of condition specific visit templates. If you have felt the loss of patient visits to commercial telemedicine sites and the explosion of urgent cares and RBC's, this is the way to recapture and maintain the medical home.

Lindsey Williams

Digital Health just went from Blockbuster to Netflix in a week. I don't think you can put that genie back in the bottle.

JOSEPH MACALUSO, Jr

Time for Change Is Now

Short answer: YES. Medicine has been too long on the sidelines in terms of using technology to increase the reach of physicians. Now is the time to push forward for appropriate reimbursement while government and private payers are realizing the great advantages and overall cost savings available It is long past due for ALL payers to recognize and reimburse telehealth visits at or close to the same rates as office visits. They save all parties time and money. The rapidly advancing use of monitoring adds to the collection of data needed to enhance judgements made by physicians. It is long past due for there to be national licensing for physicians. The absurd notion that crossing a state line renders your medical and surgical knowledge obsolete must end. Heart disease, cancer, injury, contagion etc., do not suddenly change whether in California, New York or in between. Clearly, we are at an inflection point. The time for talk and half measures should be over. These are just two basic changes, along with others, that should see relatively swift implementation.

Jamey Edwards (Expert)

Great question! Kaiser and the VA do over half their visits currently over telemedicine so the model is proven to work. Telemedicine is a group of technologies (chat, audio, video, email) that should be integrated into daily practice, helping to reduce office visits, save travel and waiting room time, minimizing healthcare's carbon footprint, and seeing patients where they are most satisfied (home and work). This is the natural evolution of healthcare's digital transformation. In addition, the B2B telemedicine market in our country has been thriving for many years. I also think behavior change takes time (adoption curve), unless there is a catalyst. Coronavirus has provided the exact catalyst to force people onto telemedicine platforms. Once people gain some muscle memory here in using the services, I believe consumers will continue to vote with their keyboards and cameras (and feet) :)

Michael Weiner, MD, MPH (Expert)

We'll need more research into what can be done safely and effectively without physical presence. There are studies about that issue for selected conditions and specialties, but we still know too little. I agree that remote monitors (BP, glucose, body weight, EKG, etc.) have changed the game, but evidence is still lacking about many issues. VA has done some innovative work such as two-step dermatology evaluations: they take a photo first, and look at it remotely or asynchronously. If it looks worrisome, they call the patient into the office for a closer look. This saves the precious office visits for the people who really need to be seen. Many derm conditions can be treated based on a photo alone. Wearables will provide the next wave of action, but also with potential to generate an overwhelming amount of data that can be difficult for even a skilled and experienced physician to interpret. The home-based continuous glucometers are undergoing quite a bit of evaluation and research at this time.

Joseph Kvedar, MD (Expert)

It will also be very important for us to have a unified message to payers and regulators as the dust settles, so we don't end up going backwards

Ujjwal Ramtekkar, MD, MPE, MBA (Expert)

What was categorized as innovation just became regular work. While direct to patient telemedicine with continue with significant demonstration of its efficacy as a covered service, the next step would be to also advocate for provider to provider models specially for areas with critical shortage of specialists.

Michael Weiner, MD, MPH (Expert)

Six provisions under new legislation in Maryland

Six telehealth provisions under new legislation in Maryland: 1. ASYNC. Adds asynchronous telemedicine to Maryland's telehealth guidelines 2. RELATIONSHIP. Allows providers to use telehealth to establish doctor-patient relationship. 3. CONTROLLED DRUGS. Establishes guidelines for use of telehealth to prescribe controlled substances. 4. MENTAL HEALTH (Medicaid). Requires Maryland Medicaid to provide telemental health services to patients at home. 5. CHRONIC DISEASE MANAGEMENT (CMS). Requires Maryland's health department to pursue chronic care management via telehealth under CMS. 6. SUD (Medicaid). Requires Maryland's health department to study whether telehealth can be used effectively to treat substance use disorder among Medicaid recipients. https://mhealthintelligence.com/news/maryland-governor-signs-new-telehealth-rules-programs-into-law
http://mgaleg.maryland.gov/2020RS/chapters_noln/Ch_15_hb0448E.pdf
http://mgaleg.maryland.gov/2020RS/chapters_noln/Ch_16_sb0402E.pdf
http://mgaleg.maryland.gov/2020RS/chapters_noln/Ch_17_hb1208T.pdf
http://mgaleg.maryland.gov/2020RS/chapters_noln/Ch_18_sb0502T.pdf

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Looking for a quick guide for implementing telemedicine?

Meg Barron

AMA, with collaborators, has developed an AMA Quick Guide to Telemedicine: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice We'll be continuously updating this with best practices, resources and updates related to policy and coverage.

Replies

RUSSELL LIBBY, MD (Expert)

and. of course, the Steps Forward module, https://edhub.ama-assn.org/steps-forward/module/2702689

What about hospital-based telehealth?

Jaron Christianson, MD, MBA

Most of the discussion surrounding telehealth has to do with virtual urgent and primary care (keeping COVID-19) patients home. I haven't heard too much about hospital-based telehealth ... TeleTriage, TeleNeuro, TelePsych, TeleICU, TeleHospitalists. How are these being affected by the recent rule changes? It seems that being able to practice across state lines isn't particularly helpful if there is still a bottleneck at the hospital credentialing phase. Have you seen these relaxed yet in an effort to get more ER, IM, CC, etc. MDs into hospitals to care for patients remotely?

Replies

Kimberly Horvath, JD (Expert)

Dr. Christianson, You are right, the focus has been on physicians providing telemedicine to help triage COVID-19 patients and continue to provide care to their existing patients. But licensing is only part of the solution, credentialing needs to be addressed as well. A few Governors have already addressed this issue, such as Governor Cuomo (NY), Governor Baker (MA) and Governor Mills (ME).

Jamey Edwards (Expert)

Emergency temporary privilege's are being granted by hospitals to help address the situation where warranted. Telemedicine is being more broadly used B2B than any other use currently and saving lives everyday in underserved communities.

Lindsey Williams

https://www.hcinnovationgroup.com/covid-19/article/21130320/at-the-largest-hospital-in-the-middle-east-a-breakthrough-on-telehealth-technologyfacilitated-covid19-care

Michael Weiner, MD, MPH (Expert)

We certainly have great needs for more "clinical telehealth" or clinician-to-clinician telecommunication. A broad need that remains unmet is the need for a more global referral network that would vastly expand access to specialists, especially for small hospitals and rural areas. Many of today's referral networks still tend to exist within small geographic areas or "closed" systems.

Tammy Weaver

To echo Jamey Edwards, we are hearing of hospitals that are exercising the disaster credentialing plan described in their medical staff bylaws. These plans define expedited processes for credentialing and privileging and apply to both physicians that have already been credentialed by the hospital or system and need broader privileges and physicians who have not yet been credentialed by the institution.

Jaron Christianson, MD, MBA

Thank you all for your replies. I am an Emergency and Telehealth Physician. TeleTriage is easily adaptable to ED/Hot Zone Covid-19 screenings. It sounds like this could actually be turned on pretty quickly with outside help - at least in some state. We are about to

release a white paper on this use, if anyone is interested. The trick is getting the information to the right people.

YAQUTA PATNI, MD
Jason I would be interested in this paper. Who do you work for? yaqutap@gmail

Jaron Christianson, MD, MBA
Here is the link: https://mailchi.mp/023c217877a7/white-paper

Joy Lee, PhD (Expert)
Hospitals also seem to be adapting and increasing remote interactions without specific telemedicine platforms, often using their existing clinician-to-clinician messaging platforms (e.g. Epic Secure Chat) and even Zoom: neither was built for tele medicine per se but both allow for video, phone, and text and are relatively widely available and user friendly.

Sandeep Jain, MD
ListenMD ready to help
I created ListenMD and can keep my hospital rounds list and billing, connect and message other doctors in my team and across teams and also send patients one link to do HIPAA compliant video chat and then voice text what I did to get a note faxed to the nearby printer that can be scanned in Cerner (eventually) As a pulmonologist, I am getting my history on video chat and entering COVID19 rooms for shortest time needed. Please try free app 'ListenMD doctor' and give feedback https://vimeo.com/397421063

Joseph Kvedar, MD (Expert)
At Partners Healthcare we have a lot of experience with physician to physician econsults, done right in the context of Epic. This works quite well as a tele-triage tool and every specialty has been involved at some level.

What is the role of asynchronous communication as part of a broader telehealth strategy as we try to address the rapid spread of COVID-19?

Ethan Bechtel (Expert)
How we use telehealth is going to evolve in the short, medium, and long term as we struggle to address COVID-19. Jay Parkinson recently posted about the role telehealth will play and specifically identifies the critical role of asynchronous communication. https://www.linkedin.com/pulse/what-role-telehealth-stage-covid-19-pandemic-jay-parkinson-md-mph/?trackingId=jBDAQxeY8%2F553oRw2zxTrA%3D%3D

Replies

Meg Barron
Thanks for sharing, Ethan. I appreciated Jay's comment: "Telehealth needs to support ongoing relationships, not transactions" - particularly important for ensuring continuity of care

Michael Weiner, MD, MPH (Expert)
That is an excellent LinkedIn post. Everyone is watching TV. Today's Internet-based TV accepts responses to users' input. Can't we use TV to track, answer questions, and help people with questions and symptoms relating to COVID19? We need the TV networks to

organize with the healthcare community. Let's do it!

Sylvia Romm, MD (Expert)
I agree with many points that the article makes and I am a huge fan of asynchronous telehealth. I also think it's important that local docs are using these technologies to see their own patients, because understanding the local situation is really important. For example, in NY and NJ, now that we are under general shelter in place restrictions, we have also pulled back from testing even high risk symptomatic persons. So it would be important to understand that many patients there should NOT be referring to drive through testing, unless they meet criteria as essential workers and are a COVID spread risk. Questions like that have little to do with modality, and much more to do with the provider behind the modality... a much overlooked piece of the puzzle.

> *Michael Weiner, MD, MPH (Expert)*
> My VA medical center is using a specific screening algorithm to determine which patients should go to the drive-thru testing tent. Clinicians are on hand to serve as consultants to review cases and triage them to the drive-through or elsewhere, depending on what criteria are met. Only the approved cases can get to the drive-thru.

Michael Weiner, MD, MPH (Expert)
Async has an important role, because in general, async is more efficient for issues that are clearly non-urgent, whereas the converse is true for urgent or potentially urgent issues (demands synchronous or live communication). So sync and async should always go hand in hand in the healthcare context. In many cases, patients know in advance that they have a non-urgent question or issue. Stopping those issues from the sync mode frees up the bandwidth and access for higher priorities. In the VA, e-mail from patients requires no immediate response but does always require a response within 72 hours.

Igor Shumskiy, MD
To Michael's point above, ideally, we should be finding ways for synchronous and asynchronous providers to work together closely to meet patients' needs. As Jay wrote, patients are waiting hours to get any sort of healthcare related guidance even before they consider a virtual visit. Most patients have no idea if a video visit is even right for them, since they've likely never used it before. We needs ways for patients to reach an on-demand, asynchronous provider (ideally RN or advanced practice) in minutes, who can empower the patient with calm, personalized health information and guidance, based on Jay's risk strat. Those patients can then be escalated to a video visit or testing site as indicated. However, many patients can be empowered to care for themselves at home, just through a quick, low-cost, asynchronous modality, such as HIPAA-compliant text messaging. Really, we need the tried and true nurse triage/call centers to be revamped into a 21st century asynchronous model that meets peoples' current expectations.

Michael Weiner, MD, MPH (Expert)
Yes, Igor, I agree, though I'm not sure what type of product is actually better than a call center, provided people do not get put on hold! I would like to know if the group has found anything helpful. I hate phone trees! Chatbots seem like they hold promise for the future but not so much the present, based on my experiences so far.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
The question of synchronous and asynchronous communications is important, and I appreciate Ethan raising it. Dr. Parkinson's point about continuity of care being a necessity is hugely relevant. In addition to my interest in telemedicine, I am also involved in CPT code creation and valuation, so bear with me, while I dive into some coding. The AMA has embraced the importance of creating asynchronous CPT codes, to complement synchronous ones. I will discuss a few. Much of our discussion on telemedicine and Covid-19 has centered on synchronous telemedicine interactions being treated the same as face to face – Evaluation and Management

Codes being the easy example. But there are recently created codes for asynchronous online communication, such as the standardized questionnaire Dr. Parkinson describes. Those codes are 99421-23 and are based on the time the service is provided (i.e. – 5-10 minutes). Another example relates to physician to physician consultation where we have codes (i.e. - 99446-9, also differentiated by time), which may be synchronous, such as via telephone. But they can also be asynchronous such as via an EHR or the internet. Granted coverage and payment for these codes should be robust, but the ability to report such services exists. It is a start. Now, getting back to Covid-19 and the continuity question. The complex nature of Covid-19 is far more than a series of single, transactional, time-based interactions. Rather, it requires continuous and coordinated actions across multiple local, regional, and national physicians and providers. Here, too, there are codes for coordination of care which form a reasonable starting template. However, Covid-19 is, and will, create a need for us to explore new and innovative payment models ready to address a need of this magnitude. We have lots to learn.

Sandeep Jain, MD

I made ListenMD for myself

As a practicing intensivist/pulmonologist I found the system of portals, ehr's all about connecting billing and data and not about patients and doctors. I had to do it myself and spent 3 years making a dream system that is now ready to help with the COVID-19 epidemic! I created ListenMD a communication system that allows patients to connect asynchronously with doctor office, and doctor to text and video chat at the DOCTOR's convenience. Patient and doctors manage the caregiver list and all (irrespective of location,EHR, organization) the patients doctors can text and share images with each other with a patented 'Distraction-free messaging' We doctors have to respect each others time but also connect as humans rather than just doing 'interoperatibility' and getting more data overload. Please feel free to load 'ListenMD doctor' app and invite patients load 'ListenMD' app. This free for all at present given COVID19. I am using my apps in office and in hospital. https://vimeo.com/397421063

Jamey Edwards (Expert)

"Telemedicine" is a broad category encompassing multiple technologies that include both Asynchronous and Synchronous tools. Asynch allows for the time shifting of care for lower acuity issues while as as capabilities to monitor patients pre and post surgery or visit. Companies like CaptureProof have provided great asynchronous tools which use AI for image processing in a number of compelling use cases in Ortho, Neurology and the Pharma markets. Also know as store and forward telemedicine, Asynch allows providers to organize their workdays to be efficient and respond within reasonable timeframes. It also does the same for the patient. It will absolutely be an important part of delivering a continuum of care in our healthcare systems future.

How do you assess physical findings such as pulse irregularity or adventitious lung sounds by telemedicine?

Michael Zimmer, MD MACP

Replies

Michael Weiner, MD, MPH (Expert)

Of course there are electronic stethoscopes, and smartphones and wristwatches, to do this remotely, but they would be needed at the patient's end. Some of the smartwatches have pulse readers and some do not. Actually, I just went on my Android to see what I could find. Located an app called Heart Rate Monitor. Downloaded it. You put your finger directly on the camera, and it displays a graph plus the heart rate. Amazingly cool! Attached. If you look at this graph and think I'm dying, please send me e-mail at your

earliest convenience within the next 7 days.

RUSSELL LIBBY, MD (Expert)
It is an important point and some would say "there's an app fpr that." There are a lot of remote monitoring devices and the AMA has been focused on that as well. I think AMA staff could identify some links to those resources. Lung sounds are always best with a hands-on exam with all of the other nuances we become facile with assessing patients, but there are apps for that too. If this covid moment persists, we may find out how well they work

Michael Weiner, MD, MPH (Expert)
I agree! Where to listen, how to listen-- all the things we are taught-- would be tricky without at least a bit of training. Difficulty of lung sounds > heart rate & rhythm, I think. Without advance training, we could probably still teach people, remotely, to echo their heart beats audibly, but this might benefit from a bystander doing the same thing concurrently for that person, to validate the findings. I'm not aware of studies about this, but there might be some. These are all makeshift "DIY" methods, of course. Use at your own risk!

Joseph Kvedar, MD (Expert)
I have also heard of doctors doing video visits with patients and asking them to collect vital sign information while they witness. Not the most efficient way to do it but as we rush to get everyone cared for it is simple and straightforward.

Michael Zimmer, MD MACP
We currently have patients report their vital signs when we do Televisits. I found an App called Cardiograph in the App Store on my iPhone. However, I worry about my 80 and 90 year old patients ability to find & download app, open app, hold their fingers on the camera and then show me the phone in the webcam. I have diagnosed countless number of 80 & 90 year olds with atrial fibrillation triggered by detecting an irregular pulse on examination who came in the office for "routine" visits. We need to improve the ease of use of this type of App for our elderly patients.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
A related coding consideration
Dr Zimmer's question is important. I am going to bring up a pertinent coding related issue, as it relates to the physical exam. But, first I want to make it clear that I am not questioning the importance of the physical exam and I am not suggesting it is not necessary or that it can be replaced – that is a decision based on each physician and his/her patient based on clinical (and practical) considerations. Here is the coding consideration: The documentation requirements for the new patient E/M codes require a physical exam, which telehealth generally does not enable. For these new telehealth provisions to be useful from a practical perspective, the physical exam requirement would have to be waived. And it is not just Medicare which will need to waive that requirement, but also the private payors. It is my understanding that the AMA and others have reached out with just that recommendation. For the established patient codes, a physical exam is not required, as long as history and medical decision making are performed. Therefore, less of a consideration for those codes.

Ujjwal Ramtekkar, MD, MPE, MBA (Expert)
Reliability of 'apps'
There are several apps available that claim the ability to capture one or more vital signs. However, the reliability and safety cannot be guaranteed. Safer route is to make available the integrated peripherals that can send periodic or real time data to the EHR. It is feasible (and cost effective) for a hospital system or an ACOs but may be challenge for independent practitioners until the EHR

vendors start offering it as a feature.

Has CMS relaxed the limitations around providing telehealth visits to patients who live in a state I am not licensed in?

Christopher Garofalo, MD

I work on the MA/RI border and am licensed in MA only. I take care of patients from both states in my MA offices. My reading is that I am not allowed to do telehealth with patients who live in RI. I believe these are state BOM regs. Thank you.

Replies

Kimberly Horvath, JD (Expert)

Many state boards of medicine are allowing license reciprocity or expediting temporary licenses for physicians licensed in good standing in another state. This will improve the ability of physicians to continue to treat their patients during the pandemic - including physicians in border towns like yourself. The RI Department of Health is issuing temporary licenses (90-day) to licensed out-of-state physicians at no cost. To apply, simply go to the RIDOH website. https://health.ri.gov/licenses/

Christopher Garofalo, MD

Ms Horvath, Thank you for the response. I will be applying tonight. I appreciate your time to contribute to this site. It is exactly what we need! Chris

JOSEPH MACALUSO, Jr

Is it not time for the AMA to lead the charge to change the archaic state by state licensing requirements? We know the history of state boards medical licensing, both good and bad, but surely we can find a way to have national licensing and still achieve local oversight of those actively practicing in a given geographic location. For telemendicine/videomedicine etc to achieve its full potential long term we need to be able to consult across state lines etc and have some form of reimbursement follow for those professional services. This would greatly increase the clinical access and reach of major centers to physicians and patients on a national basis. Thoughts?

I have heard rumblings that Medicare will allow physicians to conduct audio only/telephone visits in addition to video visits. Does anyone know if this is being addressed?

Christopher Garofalo, MD

Replies

Sherry Smith, MS, CPA (Expert)

CMS convened a public conference call "Lessons from The Front Lines: COVID-19" this morning. In a response to a question, CMS

Administrator Seema Verma noted that an Interim Final Rule announcing additional Medicare policy related to the COVID-19 crisis is expected to be released within days. We are hopeful that CMS will address payment policy related to phone calls and other services. I will circle back to your question once the Rule is released.

> *Suzy Engwall*
> Thanks Sherry. I'd like to know the answer to this as well. What about the uninsured? I am curious to know if you are aware of anyone discussing to how make telehealth available to this group as it relates to COVID-19?

Christopher Garofalo, MD
Ms. Smith, Thank you very much for your response. I appreciate the time you are all putting into this site. Chris

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
CMS will pay for telephone services
The interim final rule released yesterday indicates that CMS will pay for services by telephone during the emergency. Those codes (98966-68; 99441-3) were not previously covered. The payment amounts are not as high as comparable E/M codes but it is a start. And the right thing to do.

Christopher Garofalo, MD
Thank you Dr. Silva! Can you please clarify how the 98966-8 codes should be used vs the 99441-3? I have read the CPT definitions but can't figure out the difference. Many thanks for what you are doing.

Sherry Smith, MS, CPA (Expert)
99441-3 reside in the Evaluation and Management section of CPT. Many payors, including Medicare, will only pay claims related to the E/M to physicians and certain other qualified health care professionals. To ensure that other health care professionals may report their telephone services, CPT created a set of mirrored codes, 98966-8. Example of health care professionals who may report 98966-8 include physical therapists, occupational therapists and speech pathologists.

> *Christopher Garofalo, MD*
> Again, thank you for your response. Have a good week.

Does the AMA have any special coding advice for telehealth services related to the COVID-19 crisis?

Sherry Smith, MS, CPA (Expert)

Replies

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
AMASpecial coding advice during COVID-19
Thank you for raising this question, Sherry. I know you and the AMA's CPT / policy / clinical experts were involved in the below document. It is an excellent summary of clinical scenarios and appropriate coding/reporting. I assume this is a living document, so

others on this PIN discussion should share additional scenarios which they are seeing in their communities but are perhaps not captured in the document. The AMA, I am confident, would be pleased to construct those additional scenarios. Likewise, as we are all learning, share any corrections, additions or alternatives which may be pertinent. https://www.ama-assn.org/system/files/2020-03/covid-19-coding-advice.pdf

Sandeep Jain, MD

Documentation of level of virtual visit

I saw 10 patients yesterday on my own video app (ListenMD doctor) and called in medication renewals etc. A basic note created from voice to text said what the patient felt and what I did and was auto faxed from the app to document virtual patient visit. I still went to my emr, created encounter but felt odd detailing all the problems in the plan. So, if a basic call is made to renew meds, what codes to use and if a full review of EHR and review of labs, CT scans is made (short of physical exam), how best lo code especially now with COVID crisis?

Sherry Smith, MS, CPA (Expert)

AMA releases special coding advice related to COVID-19

New guidance from the AMA provides special coding advice during the COVID-19 public health emergency. One resource outlines coding scenarios designed to help health care professionals apply best coding practices. The scenarios include telehealth services for all patients. Examples specifically related to COVID-19 testing include coding for when a patient: comes to office for E/M visit, and is tested for COVID-19 during the visit; receives a telehealth visit re: COVID-19, and is directed to come to physician office or physician's group practice site for testing; receives a virtual check-in/online visit re: COVID-19 (not related to E/M visit), and is directed to come to physician office for testing; and more. There is also a quick-reference flowchart that outlines CPT reporting for COVID-19 testing. A new web page on the AMA site also outlines CMS payment policies and regulatory flexibilities related to COVID-19. Check the AMA COVID-19 resource center to stay up to date and for additional resources https://www.ama-assn.org/system/files/2020-03/cpt-reporting-covid-19-testing.pdf
https://www.ama-assn.org/delivering-care/public-health/cms-payment-policies-regulatory-flexibilities-during-covid-19
https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians

Joseph Kvedar, MD (Expert)

Things keep evolving (in a positive way). We are bringing 11,000 providers up to speed on how to do virtual care. Options range from video, to asynchronous, to phone calls. The provider makes the decision which modality works best for the clinical scenario and in MA, all of our payers have promised to pay at parity with f2f. The big question in my mind is whether patients will ever want to go back to the old way once the dust settles.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

Turns out the telephone is pretty important

We are finding that many patients, and not just seniors, have relatively little experience with audio-visual platforms like Skype or Zoom. This is certainly understandable – many of us are comfortable with these interfaces because our professional responsibilities demand it. Those whose jobs do not have less reason to be well versed. Which gets us back to the original question? Will audio only (aka telephone) be covered? There are a couple of options here. One is simply to allow payment parody with face to face service such as office-based E/M. There also is a set of telephone consultation codes, 99441-3, which are differentiated by time. The challenge with these telephone codes is that CMS does not cover them. Either of these two solutions would help in the short-term. Thank you to the AMA for working on this on all of our behalfs.

Potential roles for students in telemedicine?

Kimberly Lomis, MD

Many educational programs are curious about the potential to include students in telemedicine efforts to allow them to remain clinically engaged during the COVID-19 outbreak. What are your thoughts regarding appropriate supervision, privacy if triangulating calls, or other regulatory concerns?

Replies

Joseph Kvedar, MD (Expert)

Telehealth is a great platform for medical student and resident education. It is like an OSCE but the student/resident does not perceive it as such. I always ask patient's permission to involve trainees, which should take care of the privacy concerns. For asynchronous exchanges, it is more about transparency; letting the patient know that a student is involved in the care and being specific about what roles people have as they touch the communication thread.

RUSSELL LIBBY, MD (Expert)

It is a novel educational opportunity but will likely be a baseline part of their professional future. I do not know if there are an guidelines and it might be something we start to develop. I think it can expand access to mentoring and can be done remotely, ie 3 way. Yes, it is important to have disclosure and permission. A new frontier!

Have you visited the Resources tab?

Celine Witherell, AMA

Check out the Resources tab to see guides and other learning modules. Have a resource you'd like to share? Comment below!

Do you see the implementation of telemedicine in physician practice as an essential part of the medical home (or PCMH)?

RUSSELL LIBBY, MD (Expert)

There are many concepts around the medical home and how we can maintain the connection with the patient and telemedicine can provide that with a minimum of inconvenience to the patient. The issue will be around payment, tracking outcomes and costs. Care coordination was a start, but this is the way to enhance it, especially if we can coordinate it with any relevant remote monitoring.

Replies

Michael Weiner, MD, MPH (Expert)

As noted earlier, telemedicine encompasses many modalities, including portals (including secure messaging), which are already a part of every major EHR system. Telephone care is telemedicine, as is "video care", and so on. Although some patients do not want or require these forms of care, many patients benefit, and perhaps nearly everyone has used a phone to call a medical office about a

symptom. Thus, yes, not only *should* we enable and financially account for the uses of these various technologies, but we *must* do it to provide what I would consider to be the standard of care. There are lots of questions to be answered, regarding insurance, coding, security, and coordination-- not to mention medical indications for telecare-- but we're not in a position to retreat into the dark ages. As bad as COVID-19 is, perhaps a bright spot is the increased recognition of the value of telehealth care. Although we know a lot about the digital divide, that divide has narrowed quickly with mobile devices, cellular service, and the expansion of wifi, such that telecare can now decrease disparities and improve access. The physical distance can be a plus in a pandemic! I hope we don't have to realize that benefit as frequently as the others.

Learn more how the AMA is supporting The Telehealth Initiative to Improve Access to Quality Health Care with The Physicians Foundation, TMA, MMS and FMA

Meg Barron

https://www.medicaleconomics.com/news/coronavirus-could-boost-telemedicine-use

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EMTALA- MSE - Telemedicine- Coronavirus

Carrie Baker, DO

Is the AMA advocating for telemedicine to count as a medical screening exam under EMTALA? Currently, my network has not approved use in the ED due to this.

Replies

Sandy Marks (Expert)

We anticipate that CMS will issue a new rule soon with additional COVID-19 policies and flexibilities. This rule may include changes to EMTALA such as allowing EMTALA screening via telehealth.

Jamey Edwards (Expert)

I know of Rural hospitals that are using telemedicine to staff their ED's. Bryan Health is doing it as staffing some of those facilities are challenging otherwise. Brochure attached here. As far as EMTALA, on call services are currently being used to satisfy requirements under EMTALA and CMS supports it (https://go.cms.gov/3apUM9U), but I haven't seen anything yet on telemedicine as the sole source for a medical screening exam. Would love to know if others have know otherwise.

Kevin Shick

Using Telemedicine as the sole source for the initial medical screening exam should be covered to satisfy the requirements under EMTALA, correct? Otherwise how is Bryan Health proceeding past the telemedicine step?

Jamey Edwards (Expert)

For rural applications where no other physician is available: If no onsite physician is needed, the Telemedicine Physician performs the complete encounter. Telemedicine carts used in this environment are equipped with a stethoscope and examination cameras

for the exam. If an onsite physician is needed (for a procedural need), the Telemedicine Physician can start labs and/or Radiology orders while the physician is en route. This model exceeds the level of care with the on-call only ER coverage model that many rural hospitals use.

Is CMS allowing AWVs to be done by video visit? I have heard that the G4039 code is covered from some people but others say not. Can you please clarify? Thank you.

Christopher Garofalo, MD

Replies

Sandy Marks (Expert)

Currently Annual Wellness Visits are not on the list of services that Medicare covers via telehealth. The AMA is expecting a new regulation on COVID-19 to be issued by CMS soon and that regulation may expand the telehealth list.

> *Mitch Evans*
>
> Hi Sandy, In FAQ #4 of this latest article from Medical Economics, Annual Wellness Visits (specifically G0438 and G0439) are included covered services that can be delivered via telehealth under the COVID-19-related changes to the program. https://www.medicaleconomics.com/news/coronavirus-cms-eases-restrictions-telehealth-and-virtual-services/page/0/4?amp%3BGUID=9DED6344-66C2-4D1D-877E-E73369900692&amp%3Belq_cid=91195&amp%3Belq_mid=11260&rememberme=1 This is also consistent with the list of services included in the recent CMS fact sheet on the topic released earlier this month (note: you have to manually enter the URL listed in the table at the bottom to get to the link with the XLS): https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

Christopher Garofalo, MD

On the list of covered telehealth services Go439 is listed: G0425 Inpt/ed teleconsult30 G0426 Inpt/ed teleconsult50 G0427 Inpt/ed teleconsult70 G0436 Tobacco-use counsel 3-10 min G0437 Tobacco-use counsel>10min G0438 Ppps, initial visit G0439 Ppps, subseq visit G0442 Annual alcohol screen 15 min G0443 Brief alcohol misuse counsel G0444 Depression screen annual G0445 High inten beh couns std 30m G0446 Intens behave ther cardio dx G0447 Behavior counsel obesity 15m Ms. Marks, can you kindly comment on this? Thank you

Sherry Smith, MS, CPA (Expert)

Yes, these codes are on the CMS list of telemedicine codes. The AMA has published the CMS list, updated to include the codes added yesterday. The list may be viewed at: https://www.ama-assn.org/system/files/2020-03/telehealth-services-covered-by-Medicare-and-included-in-CPT-code-set.pdf

Kimberly Hardy, MD

For G0438 and G0439 via telehealth -vital signs needed?
when doing G0438 and G0439 via telemedicine - are the vital signs still a required piece?

Naturopathy

Suzan Hauptman

Has anyone seen any verbiage around changes to naturopathy telemedicine visits?

Replies

RUSSELL LIBBY, MD (Expert)

I am not sure what you might mean by this. If someone is a physician and bills for a telemedicine visit for medical care, it should not matter if they believe in or practice naturopathy or any other alternative modality.

Suzan Hauptman

Nauropathy

If the clinician is a naturopathic physician; licensed in some states, but not all.

Will telemedicine visits reduce medical costs and will it be shared back with the care providers

RUSSELL LIBBY, MD (Expert)

Telemedicine has significantly reduced the use of emergency rooms as well as helped treat many conditions, acute and chronic, that may have had more expensive outcomes when treated in a facility. Elective surgeries have been postponed or canceled and hospitalizations for non-acute and protocolized conditions and treatment have been avoided. This has resulted in significant savings for insurance companies. How should care providers be rewarded for this stewardship?

Replies

Michael Weiner, MD, MPH (Expert)

The relationship between quality of care and cost of care is complex. Less care does not always mean better care-- nor does more care. I'm not sure I would call this stewardship as much as necessary shifting in a crisis. In many cases, I think that we will see that outcomes appear comparable with telemedicine, with a lower cost. Nonetheless, the outcomes of the current shifts are unknown and will be important to study. There are bound to be some adverse events in the mix.

Ilya Glants

I guess the reward is reimbursement for delivering the service, or do you mean other kind of reward?

Originating site fee

Suzan Hauptman

Q3014 is the originating site code. Is this billable (and how) if the patient is in a hospital (not rural) and the physician is elsewhere?

Latest CMS announcements

Meg Barron

Centers for Medicare & Medicaid Services announced a number of new policies to help physicians and hospitals during the COVID-19 pandemic. The AMA released a statement applauding these actions, which include Medicare coverage for telephone services, significant additions to the list of covered telehealth services such as emergency visits, and greater clarity on the use of remote patient monitoring for acute conditions like the novel coronavirus: https://www.ama-assn.org/press-center/ama-statements/ama-applauds-administration-effort-cut-red-tape-during-pandemic

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If you're a physician or practice that recently implemented telemedicine, let your patients know!

Stacy Lloyd, MPH

We've had some questions come through regarding whether or not physicians are allowed to proactively tell patients about their new or existing telemedicine offerings! The answer is yes! So, consider working with your practice/team to support patient outreach, and post announcements on your website, patient portals and other patient-facing communications!

What are any best practices you could share as you've implemented telemedicine with your patients?

Celine Witherell, AMA

Replies

Michael Weiner, MD, MPH (Expert)

Especially for older patients, many newer technologies are foreign and non-intuitive to them. They need as much simplification as possible with the steps and requirements. Written instructions tend to be a plus. Getting them comfortable with frequent, short, easy, well explained routines is a plus, so that the focus can then be on them as individuals. We also do not need perfection with technologies; we need approaches that are "good enough"-- good enough for effective communication and decisions, without going much further. Another issue is expectations: we need clarity about each person's role, what is expected of them, "do's and don'ts", and the timing.

Meg Barron

Additional resources/articles of interest

Great question - continue to check AMA's Telemedicine Quick Guide for best practices that is continually being updated: https://www.ama-assn.org/practice-management/digital/ama-quick-guide-telemedicine-practice Here's some additional recent

articles of interest: https://www.hcinnovationgroup.com/covid-19/article/21130678/at-jefferson-health-a-success-story-around-ed-teletriage-that-offers-hope-in-the-emerging-covid19-pandemic
https://www-wsj-com.cdn.ampproject.org/c/s/www.wsj.com/amp/articles/icus-leverage-remote-doctors-and-telemedicine-to-manage-coronavirus-deluge-11585368006 https://www.medicaleconomics.com/news/coronavirus-practice-guide-part-2-crisis-could-boost-telemedicine-use
https://www.bostonglobe.com/2020/03/26/opinion/could-coronavirus-push-telehealth-forefront-medical-care/

Saif Khairat, PhD, MPH
Hi- here is a good but brief report on best practices: https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0091 We are also publishing a paper on telehealth best practices:
https://www.researchgate.net/publication/340522859_Evaluating_Virtual_Care_Experiences_for_Patients_with_Covid-19_Chief_Complaints_Best-Practices_Recommendations_Preprint

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What changes are there to remote patient monitoring during the emergency declaration?

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
The Covid-19 related interim final rule released yesterday includes provisions to help physicians care for patients while keeping both parties free from unnecessary exposure. One of the important updates during the emergency relates to remote patient monitoring. Those services can now be provided to both new and established patients for both acute and chronic conditions. This is an important update. This could include, say, pulse oximetry monitoring of a Covid-19 positive or suspected patient. There are quite a few codes to consider, several of which are time-based, such as 99457-8.

Replies

Michael Weiner, MD, MPH (Expert)
Can you clarify the question? Are you asking about changes to policies, practices, needs, or something else?

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
Thank you, Dr. Weiner for asking. I was just answering my own question about yesterday's regulatory updates to the remote patient monitoring (RPM) codes. They are now more broadly available for reporting, coding and billing purposes. But, I would be interested in applications which could enable their clinical use.

> *Sylvia J Trujillo*
> Medicare payment policy change
> Also, to clarify the interim final rule with comment concerns the Medicare program's payment policy. Please consult the policy of commercial payers and state health programs to ensure that they have the same coverage policy. The organization that I work with — Compassion & Choices — focuses on ensuring access to care for patients with terminal conditions. We have asked most state governors and legislative leaders to ensure coverage and payment parity for telehealth and other virtual care services in state funded healthcare programs and among commercial payers during COVID19.

Git Patel, CEO

It's a tool that can be utilized to monitor patients in isolation at home and still get paid for tracking and monitoring COVID 19 and Non Covid 19 Patients.

Carrie Nixon, Esq.

Good changes relating to RPM, but more to be done. https://www.nixonlawgroup.com/nlg-blog/2020/3/31/cms-issues-interim-rule-on-use-of-telehealth-remote-patient-monitoring-e-visits-and-virtual-check-ins-during-covid-19

What are the telehealth updates from the recent CMS Covid-19 Public Health Emergency Interim Final Rule?

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

Replies

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

The services covered are much broader

The rule allows a greater range of services which may be provided via telehealth including: ED visits Inpatient care Nursing Visits Critical Care Domiciliary Care Home Visits Neonatal and Pedi Critical Care Neonatal Continuing Care Care Planning for Cognitive Impairment Psychological and Neuropsychological Testing PT and OT Radiation Treatment Management Social worker, clinical psychologist, speech language pathology services

Carrie Nixon, Esq.

Lots! See https://www.nixonlawgroup.com/nlg-blog/2020/3/31/cms-issues-interim-rule-on-use-of-telehealth-remote-patient-monitoring-e-visits-and-virtual-check-ins-during-covid-19

National Licensing

JOSEPH MACALUSO, Jr

Is it not time for the AMA to lead the charge to change the archaic state by state licensing requirements? We know the history of state boards and medical licensing, both good and bad, but surely we can find a way to have national licensing and still achieve local oversight of those actively practicing in a given geographic location. For telemendicine/videomedicine etc to achieve its full potential long term we need to be able to consult across state lines etc and have some form of reimbursement follow for those professional services. This would greatly increase the clinical access and reach of major centers to physicians and patients on a national basis. Thoughts?

Replies

Michael Weiner, MD, MPH (Expert)

From the purely medical point of view, the state boundaries of licensing often create a barrier to delivering the best care. There are issues to resolve: how to interact effectively with state departments of health, comply with state-based medical regulations, and so

on-- so a solution is not as straightforward as creating one national licensing application and approval process, or one national "telehealth approval". I'm still in favor of trying to make it work, and resolving the issues, because it will help the patients in need. The benefits of a national solution would seem to outweigh the risks or costs, at least in principle.

JOSEPH MACALUSO, Jr

Agree

Thank you and I fully agree. Any step forward will have issues to be ironed out. Yet, the rapidity of technological change and innovation demands that medicine not lag behind. Just as the training system was revolutionized over a century ago by Halsted, so too must our delivery system be revolutionized to take advantage of the many new innovations for health care delivery. This is particularly true in the case of chronic disease, care followup, multi-specialty consultation etc.

Kimberly Horvath, JD (Expert)

AMA supports state-based licensing

The AMA has longstanding policy supporting state-based licensure. It's important that physicians are licensed where the patient is located to protect the safety of patients, preserve the state or often local standard of care, preserve medical liability laws and a host of other laws and regulations. In short, licensure at the state level is necessary to protect the strong oversight of the practice of medicine and protect the safety of patients. The AMA does strongly encourage and support increased uniformity in requirements for state licensing requirements and the application process, as well as standardization of verification of credentials.

Michael Weiner, MD, MPH (Expert)

I can see the importance of state-based licensure from the standpoint of laws, liability, and standards. Increasing uniformity would be helpful. If there were a way to facilitate or streamline applications to states that border a clinician's home state, or reduce costs of applying to multiple states, that may help with medical care as well. What comes to mind is "common application" mechanisms that are often used by universities operating as a consortium.

JOSEPH MACALUSO, Jr

All good points to a degree. First, while it may be longstanding policy of the AMA, that does not mean that the policy should not evolve and change. Second, we already have national standards in place. For example, final licensing exams upon exit from medical school are national in scope yet only applied within a selective state when an application is filed. Would we suggest that an MD degree from Harvard qualifies that person over an MD degree from Michigan, or Duke? An MD degree is nationally recognized if from any accredited institution. Again, the various specialty boards have universal qualifying metrics and exams that are given to all qualified candidates. So is some who achieved board certification in a given discipline less certified if that person resided in California versus Ohio? Or because their training program was Johns Hopkins versus Alabama? Board certification is nationally recognized. This is also true of broader certifications, such as the FACS from the American College of Surgeons which can apply to surgeons from any discipline or any state. Food for thought I would think.

> *Carrie Nixon, Esq.*
>
> Agree. The existing policy on state licensure creates an artificial barrier to expanding patient care that need not exist.

Ved Gossain, MD

we have the DEA numbers which are Federal (I think) >We could have a federal license to practice all over the country ?

Michael Weiner, MD, MPH (Expert)

I am very supportive of a national solution. I think the question will be, what is the state's role, and a state's need, in licensing? We have state-based driver's licenses, state-based certifications for a number of things-- presumably because states may have unique and state-specific needs, based on population details, politics, state legislation, and so on. Health-related requirements and departments of health may vary by state. So all of these things would need reconciliation to make a national solution work. I certainly like the idea! The VA is perhaps a role model or example of "how to" in some of these areas, as some of the state-based requirements do not apply there, and this can lead to more seamless and efficient care for both the patients and the system.

JOSEPH MACALUSO, Jr

Again, all points to be addressed. It makes sense that any physician physically practicing in a locality should be registered with that state board so that if needed, care monitoring can occur. That should also apply in my view, to telemedicine on a national basis as long as a provider in another state registers that he or she is "seeing" patients via tele/video medicine in another particular state. I am sure that someone will raise legal questions regarding interstate commerce. Not sure why that would even apply as we already have interstate commerce on a massive scale.

Ved Gossain, MD

As far as I know ,one can practice in any VA hospital with any one state license Why not extend this to other health care facilities

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Data collection Pre-Visit

Chris Barakat

First- God bless all of you at the front line serving your country! Second- I am sorry to hear about the reduction in patient volume and the uncertain future of thousands of doctors clinics. It is so hard to hear the impact of COVID-19 on you, your staff and patients. Third (the question)- Are doctors that have shifted to a large percentage of their encounters to telehealth, still using their MA's/ NPs for data collection before you begin your encounter? Please share your experiences/ feedback/ suggestions.

Replies

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

Pre-Telehealth consent

I will defer to others on the excellent question Chris poses. But, I do want to make a comment about patient (beneficiary) consent. The recently released interim-final rule. CMS, to their credit, believes that consent should not interfere with necessary telehealth services. To that end, the annual consent need not be obtained in advance of the telehealth encounter. It may be obtained at the same time. Small change, but helpful.

Christian Habermann, MBA

To lighten the load with in-take our providers have found MayaMD helpful. See https://MayaMD.ai

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Which POS to use when doing a video telehealth visit for a Medicare patient from a physician office

Christopher Garofalo, MD

When we started Telehealth a few weeks ago we were told to apply POS 2 and modifier -95 to these visits, see "Special coding advice..." from AMA. Now I have heard we are to use POS 11! Here is the link to the current "Special coding advice..." from AMA which was updated April 3: https://www.ama-assn.org/system/files/2020-04/covid-19-coding-advice.pdf . Please help, I don't have much hair left to pull out of my head! If this has changed they cannot be doing this to physician practices that are teetering as it is! Thank you, Chris

Replies

Sherry Smith, MS, CPA (Expert)

CMS released new guidance last week. In this guidance, CMS asked that the Place of Service (POS) be selected based on where the physician would have otherwise performed the service. For office visits, that would typically be POS - 11, Physician Office. Modifier 95 would be appended to the claim to signal that the service was performs via telehealth. This will be to your benefit as this is the mechanism to allow Medicare to pay at the in-person rate. Claims submitted with POS 02 will be paid at the facility rate. CMS also changed the effective date to March 1, 2020.

Christopher Garofalo, MD

Thank you for your help. It is so frustrating to have them change this in the middle. It is going to be difficult enough for private practices to make it through this without having to pour energy into these issues

Charlene Setlow

Unfortunate diversion of resources

I concur 100% with Dr. Garofalo. I can only imagine the tremendous effort, resources correcting and/or adjusting for billing changes to correct previously submitted CMS invoices. This disruption is ill-timed when we need to concentrate all our resources to save lives for not only this current pandemic but also for the next COVID-19 outbreak.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

Frustration understandable, but...

The frustration expressed is understandable. But, thank you to the AMA for identifying a shortcoming and helping CMS take steps to remedy it for the long-term betterment of physicians. Let's all keep our eyes open for other changes we can make to serve patients in this trying time.

Christopher Garofalo, MD

Dr. Silva, do not get me wrong. I am thankful to AMA for helping out on this and it does improve our revenue. I guess from a long-term perspective it kind of demonstrates just how silly our billing system is in the 1st place, doesn't it? First you have to figure the E/M code, then add the POS, then add a modifier. There is no need to be this complex, unless the goal is to complicate payments to the ones who are doing the work. I am a Delegate to the AMA so I know the good work they do, but this is the time to truly reevaluate the amount of complexity and layers that have been added over the years. Thank you.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

We agree

Great points, Dr. Garofalo. Indeed, we see payment systems which have evolved in parallel over decades adding incremental layers of complexity along the way. For a time, it looked like MACRA would prompt the move from fee for service to broader bundled episodes of care. But, even that has been slow moving.

Christopher Garofalo, MD
Which is why we all need to keep up the good fight!

Piyush Kedia
Telemedicine POS and Modifier per plan
Each Payer has their own requirement for POS and Modifier and these are changing regularly as they adapt to the new environment as well. We started tracking these changes in a google spreadsheet for plans nationwide. happy to share that here.
https://rebrand.ly/a3ubaba

Resources to involve 3rd-year medical students in Telemedicine?

Harsh Patel

As a 3rd-year medical student who is almost finished with his clerkships, what resources are available to get us involved? I've experience with doing phone check-ups and managing chronic conditions amidst this COVID-19 pandemic for our schools free health clinics. I want to know about opportunities that will expand and utilize the plethora of skills medical students like me have accumulated thus far. Any ideas, opportunities and resources i can delve into?

Replies

Amanda Azadian
Good question Harsh! Connecting you with some folks
Hi Harsh, PIN Collaborator, Sling Health is discussing some of the clinical problems that are made even more evident by the stress of COVID-19. Tagging Mario, Aadit, Marcus below. https://innovationmatch.ama-assn.org/groups/clinical-problem-database/newsfeed
MD++ is also a great group of med students particularly interested in digital health. They are based in New York and I'm tagging their leader Sherman for you as well! Best,

> *Christian Habermann, MBA*
> check us out too, https://mayamd.ai

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)
Check out our resources in Texas
Great question, future Dr. Patel. The Texas Medical Association has created a resource page for our physicians. https://www.texmed.org/Telemedicine/ Lots of great content to browse and even several forms and policies ready to be put into place. As has been discussed in this PIN, COVID-19 has dramatically and quite appropriately accelerated the momentum to enable telemedicine. One important dynamic is the growth in physicians providing telemedicine services. Not surprisingly, we are learning that telemedicine requires a complementary, but somewhat new, set of skills. Which is why I am thrilled to see a 3rd year medical student like you interested, since it is not too early to learn.

Mario Russo

Contributing to Innovation through Sling Health!

Hey Harsh! Thanks for posting. There are so many ways to contribute to healthcare even if you can't get in the clinic currently. A highlight of mine is bringing awareness to the problems currently facing healthcare providers and patients, and then contributing your expertise to help solve these problems. If you've identified problems, you can engage with discussion around that problem at the Clinical Problem Database: https://innovationmatch.ama-assn.org/groups/clinical-problem-database . Highlighting anything that could use some broader discussion, brainstorming, and solving is very valuable! Furthermore, your clinical background and experience is crucial in developing healthcare solutions sensitive to the experiences of providers and patients. You can work to solve problems by engaging with Sling Health (slinghealth.org/) and potentially also getting involved with our COVID19 bootcamp being hosted in May (slinghealth.org/bootcamp).

Harsh Patel

Thank you so much for your thoughtful answers, I have definitely found opportunities and am looking forward to connecting with like-minded individuals in these coming weeks!

Christian Habermann, MBA

Stay positive, curious and healthy:)

STEPHEN MLAWSKY, MD, CMM, FAAFP

STATworkUP® DDx Clinical Guide

At the forefront of AI technology, IatroCom® built STATworkUP®, an innovative diagnostic medical app for mobile smartphones. The software program runs on the latest iPhone, iPad & Android devices. It is one of the very best medical apps on the market, providing fast problem-oriented information to enable a new era in healthcare delivery. This modern tool was created, over many years, to help improve clinical practice. From the start it was designed to assist healthcare providers do complete evaluation and assessment of concerns. It supports a new approach to patient encounters by caregivers. Doctors, and nurses tell us they love it. STATworkUP is really a very good value and quite beneficial to own! It quickly correlates symptoms, suggests appropriate lab tests, rapidly integrates findings, and instantly computes differential diagnoses for consideration. The app associates pertinent criteria for over 3,000 conditions to facilitate treatment decisions. It offers fast best-practice guidelines. And it links to related subject matter expert web pages for everything in its large, comprehensive knowledge structure that contains over 12,000 topics plus standard names and synonyms. It includes disease descriptions, etiologies, epidemiology, manifestations, risk factors, causes, complications, remedies, indications, contraindications, adversities, side-effects, interactions and more Read more about it here: https://www.statworkup.com See it in action here: https://youtu.be/Axby_fLy8ps You can get the latest version of STATworkUP now, to improve comprehensive examinations, and enhance excellent care: https://apps.apple.com/us/app/statworkup-ddx-clinical-guide/id349985116 https://play.google.com/store/apps/details?id=org.iatrocom.statworkup https://www.amazon.com/STATworkUP%C2%AE-Clinical-Differential-Diagnosis-Guide/dp/B0851WGQCW/ref=sr_1_1?keywords=statworkup&qid=1583166312&s=mobile-apps&sr=1-1 https://innovationmatch.ama-assn.org/posts/16526

What are some of the top startups addressing COVID-19?

Ava Asgari

Plug and Play is hosting a series of COVID-19 webinars highlighting the top startups across different industries that have

existing technology solutions that can be quickly implemented and that have specific COVID-19 use cases. Check out the recorded sessions from our last two sessions with our partners at BARDA (Division of the U.S. Department of Health & Human Services) and Roche Diagnostics here: https://www.plugandplaytechcenter.com/covid-19/

Replies

Christian Habermann, MBA

Thank you! check https://mayamd.ai

Peter Hayes

Made another post but applies directly to this. https://youtu.be/xdfR-dr3Ty0

Language and Disability Access Tool for Front Line Care and Telehealth Made Free to Help with Pandemic

Peter Hayes

Communication during this time of crisis is critical. TranslateLive's award winning software was just made temporarily free ($500 value) for anyone to use with no signup, email or questions asked. Please see video for more details. https://youtu.be/xdfR-dr3Ty0

Collecting Health Equity Data amid COVID-19

Celine Witherell, AMA

The AMA's Chief Health Equity Officer, Dr. Aletha Maybank cites a lack of racial and ethnic data relating to COVID-19 in her recent NY Times op-ed piece. Dr. Maybank writes, "This data is central to understanding injustice and ensuring the optimal health of people, but it is gravely missing in this crisis — missing from health department websites, daily updates by political leaders and, until recently, news reports." How can we gather this data to better understand and address these health inequities? What do we risk in not collecting this data? Can telemedicine be used as a tool to collect this data?
https://www.nytimes.com/2020/04/07/opinion/coronavirus-blacks.html

Replies

Joseph Kvedar, MD (Expert)

yes, it can but it will require a commitment by all practitioners to collect a structured series of data as they roll out these visits. Given that the implementation of widespread telehealth has been chaotic and rushed, I am, sadly, skeptical.

Amy Sheon (Expert)

Shine a light on a hidden inequality

One important thing to collect is the patient's internet access and skills. Without both, no telehealth! (Yes, they can do audio only but I call that "cellehealth" AKA second class care.

Marina Udowenko, MD

Utilizing Primary Care Physicians in their Communities

I believe it is important to have the private community physicians/groups involved in the pandemic response. I suggest smaller task forces of physicians in each community with resources to educate and test. There is disparity because the leaders of the community, have not been working with the community physicians. Over a month ago, I noticed test centers were predominantly in affluent areas, and none were close to the community where I was practicing. My patient population is predominantly Mexican, Central, and Latin American. My fellow private physicians and I tried to organize a drive by test site, even found rapid tests kits and PPE for ourselves. We just needed the funding to purchase the kits to test 50-100 symptomatic patients a day. We had bought our own PPE. I called the state offices, I called our local public health department, I called the Mayor of our Chula Vista community. We did not get support nor response to inquiries, and I could not find avenues for funding to apply for during this pandemic. I feel that in general they were not prepared and scrambling, so our concerns were not being heard. This was extremely frustrating. I am glad I started educating my patients at the end of January regarding how to stay safe, gave them masks, and instructed them to prepare for several months at home during our office visits. As a primary care physician, I know the community I practice in and understand my patient's needs.

Amy Sheon (Expert)

Are your patients able to social distance?

Appreciate the work you are doing. Do your patients have internet at home? Are they able to use telehealth? Kids able to do online school work?

Marina Udowenko, MD

Hi Amy! Most of my patients are elderly, and do not have smart phones or internet. We have been doing phone encounters, video visits with others, and patient visits for emergent issues.

Marina Udowenko, MD

I am currently working on a solution for this, though my barrier is building the technical team to assist in the programming.

Saif Khairat, PhD, MPH

We have been working on a similar study looking at social determinants and telehealth. Here is a recent study around this topic. Happy to chat if interested. https://academic.oup.com/jamia/article-abstract/26/8-9/796/5537967

JOSEPH MACALUSO, Jr

The divide that we see has been growing for decades. It is not just an economic one. It is a divide of education and skill sets. Telehealth tools are fine for the web literate, and there are many, but not for those who are web "illiterate" or lack access or band width to allow the full potential of telehealth to be realized.

> *Amy Sheon (Expert)*
>
> Providers should advocate for telehealth over celleheal
>
> Joseph--you are spot on. I hope that providers will not accept lack of patient connectivity as a given. If there was ever a time to end the digital divide, it's now. Please advocate for getting your patients connected. There are simple steps you can take, starting with screening your patients and referring them to local services if they do not have connected devices and broadband or mobile dataplans.

Curious - would it be helpful to have a Cytokine risk assessment tool that also provides clinical perspective aka next steps?

Christian Habermann, MBA

We are thinking of adding it to our free Covid-19 web tool which helps to lighten the load by automating some clinical workflows. Basically we would incorporate complex scoring systems to predict the chance of cytokine activation. Would greatly appreciate your feedback and insight. Thank you so much! Christian For reference here's our Coronavirus tool which has CDC plus additional treatment guidelines and protocols, https://mayamd.ai/coronavirus-help/

Replies

Michael Weiner, MD, MPH (Expert)

This could eventually be useful, but I don't know of a current drug or other approach that targets COVID-generated cytokines via a preventive strategy. One might emerge through findings from clinical trials.

JOSEPH MACALUSO, Jr

Helpful: Yes But...

The tool appears to be basically an algorithmic progression, therefore, the database the it is using is the key. The more data, the better the predictions it can make and the better the movement through the progression chain. The key is data in. The same would apply to a cytokine tool.

What do you do with patients unable to use telehealth?

Amy Sheon (Expert)

About one-half of low income patients lack devices, internet access and digital skills needed to use telehealth. Are you encountering patients unable to use telehealth? Do you resort to inferior "cellehealth" if they don't have video? Do you offer them any resources to address their barriers to telehealth? Would you consider adding a digital connectivity assessment as part of patient screening to identify patients that cannot use telehealth?

Replies

Saif Khairat, PhD, MPH

Great question, at UNC we offer phone or video options as telehealth communication mediums. To your point, some patients especially rural and underserved populations, have limited internet access and they typically choose telephone call for their telehealth visit. Happy to provide more around workflow if helpful.

Zeke Silva, MD, FACR, FSIR, FRBMA, RCC (Expert)

The importance of the telephone

This is such an important question. With the rapid COVID-19 related expansion of telehealth, we see that, for various reasons, many patients rely on the telephone, over AV tools. For the duration of the emergency declaration, the telephone may be used for billing telehealth encounters and they are covered by CMS (CPT codes, 99441-3). The payment rate is lower than the corresponding E/M

codes, which some have questioned. At the same time, there has been loosening of the security and compliance requirements surrounding telehealth further enabling its use, including the telephone. On a practical level, this is all a good thing. We can quickly and safely reach patients without being slowed by technology and other issues which could be barriers in normal times. But, here is what it is really important. We are living through one of the largest telehealth pilot studies in history. 6, 12, 18 months from now, we will look back on this time to objectively evaluate what worked and didn't work. And why. The quality of our interactions, patient experience, outcomes and documentation will be an important parts of that analysis.

> *David Flannery, MD*
> Dr Silva is spot on. Folks who have expanded the use of virtual visits need to plan now for how to study the implementation science, process outcomes and clinical outcomes of this response to the crisis.

Amy Sheon (Expert)
Funding is available now to buy devices for patients
The FCC has just offered funding that includes purchase of devices and dataplans for patients to use telehealth! Message me offline if you are interested in applying. amy.sheon @ gmail

Git Patel, CEO
Compassionate Case Managers
You provide technology along with compassionate staff that hand holds patients who are not able to use technology via non face to face interactions that is getting reimbursed under CMS as Chronic Care Management.

Samant Virk, MD
It's about the care, not the tech
Great observations here. We are seeing and speaking with a lot of practices who are conducting telephone visits. As clinicians, we have been providing care and advice over the phone for years and know it is helpful and easy (although uncompensated prior to the past month). If someone does not have access to internet or is not tech savvy it's a tried and true option. While doing visits over video would be optimal (having two senses of sight and sound involved in a clinical interaction offers more value than one) in the end the most important thing is that it's about providing the care and advice - the means by which it is conveyed becomes secondary if technology is a barrier.

What do you do with patients unable to use telehealth?

Amy Sheon (Expert)

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Replies

Wessam Sonbol
Telehealth devices

Hi Amy, we at Delve Health (www.delvehealth.com) utilize a hybrid approach to engage patients. For ones that do not have devices, we ship out the device to them. However, the provider or pharma organization pays for that cost.

Amy Sheon (Expert)
That's a great approach. Do patients need/get technical support to use devices?

Is the legal address of the patient or the physical location of the patient critical when conducting telehealth across state lines?

Christopher Garofalo, MD
I have a MA licencse and practice in MA on the border of RI. Can I do a telehealth visit with a patient who has a lives (has a legal residence) in RI? What if that pt has a legal residence in RI but is visiting family in MA? Can I provide telehealth services while they are in MA? If I have snowbirds who travel to FL for the winter, does their legal residence have to be in MA to provide telehealth services? I guess the question is when providing telehealth service is it the legal residence or phyisical location of the patient that matters? Thank you in advance.

Replies

Michael Weiner, MD, MPH (Expert)
I'm not an attorney, but my reading of this suggests that, for CMS, any location within the national emergency area would qualify, though a facility fee would not be covered outside the usual (non-emergency) qualifying locations.

JOSEPH MACALUSO, Jr
Does the physician's physical location matter?
Does the physician's physical location matter? Meaning, regardless of patient location, is the physician able to conduct a billable event if at that home for example? Or must they be in their usual practice location or hospital? Must it be on a formal EMR system?

Carrie Nixon, Esq.
Medicare's waiver does not obviate state licensure
Hi Joseph and Christopher - the short answer is, it varies by state. Although CMS issued a waiver allowing licensed providers to render services outside their state of enrollment, this does NOT obviate the need to follow state licensure requirements. Now, many states have altered their licensure requirements over the last several weeks, but the waivers are not consistent. If helpful, take a look at this webpage: https://www.nixonlawgroup.com/covid-19-telehealth-and-rpm-resources

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I am curious to see what the group thinks about using telemedicine along with remote monitoring devices for chronic patients

Seth Merritt
We are building a product incorporating both traditional telemedicine (voice and video consults, secure messaging, etc.) along with connectivity to monitor patients' vitals like BP, glucose, pulse ox, etc. to actually try to manage the patient fully virtually. It seems

like a requirement in these times when these types of higher-risk patients are most vulnerable to coming into the practices. Has anyone in this group experienced something like that or have thoughts in how it might be implemented in a practice managing conditions like diabetes and hypertension? It also was intended to help practices offset the revenue losses from the lack of patients coming on site by creating the infrastructure needed to bill for remote monitoring, chronic care planning, and virtual visits. If anyone has some feedback or would be interested in piloting with us, I would love. to get that feedback. Stay safe!

Replies

STEPHEN MLAWSKY, MD, CMM, FAAFP
Don't forget weight, pulse rate

> *Seth Merritt*
> Agreed!
> We are tracking a lot of the user measurements like weight, BMI, glucose, BP, HR, movement, sleep pattern, activity level, EKG, etc to try to give a physician a complete view of their patients regardless if they have the ability to come into the office or not. There are so many data collection opportunities out there, we are trying to collapse that all down into a simple to use app for the patient and a consolidated web portal for the physician to manage or integrate the data back into their EMR. It will be interesting to see where the demand for those services moves in the combining months and years as patients' and physicians' behaviors evolve.

STEPHEN MLAWSKY, MD, CMM, FAAFP
And temperature of course

Michael Weiner, MD, MPH (Expert)
Could have a look at Datos. https://www.youtube.com/watch?v=MkpO5CIk6i8
https://www.datos-health.com/

> *Seth Merritt*
> That's a good analogy
> Thanks for sharing! That is similar to what we're doing, but focused more on chronic health, so imagine that home hospitalization patient with diabetes automatically streaming their weight along with the glucose & activity levels up to her doctor. Is your practice doing anything like that now, or contemplating something? Do you have any input on how it might be used in your clinical setting? I appreciate the feedback!

Michael Weiner, MD, MPH (Expert)
VA uses remote monitoring for chronic disease mgmt
The VA does use remote monitoring devices in its telehealth program, for chronic management of hypertension, heart failure, diabetes, and other conditions. It also has a home video connection service for use with patients. These two systems are not usually used in tandem currently-- remote monitoring is often coupled with telephone discussions-- but they certainly could be at any time, without the need for technical modifications.

Amy Sheon (Expert)
Addressing barriers to patient use of connected devices
Do you have a way to identify and reach patients who are not currently connected to or comfortable using the internet and devices?

I encourage you to connect with the National Digital Inclusion Alliance (digitalinclusion.org) to identify organizations in your community that know how to help individuals get devices, free or low cost dataplans and basic digital skill training. We can also help train your staff to provide the technical support that patients may need to use these devices. Contact me for more info: asheon@digitalinclusion.org

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Please enroll in this 200m Telehealth Program that opened yesterday.

Git Patel, CEO

https://www.fcc.gov/covid-19-telehealth-program-frequently-asked-questions-faqs

This includes Remote Monitoring of patients in section 14. Please partner with companies to receive these reimbursements.

Replies

Carrie Nixon, Esq.

Just keep in mind that the definition of "eligible providers" is a bit restrictive.

Amy Sheon (Expert)

Resources to help with applications

This is a phenomenal opportunity to connect the 37 million U.S. households that lack internet and connected devices. I urge anyone considering applying to connect with local and national organizations that are expert in connecting unconnected households. The National Digital Inclusion Alliance (https://www.digitalinclusion.org/) institutional members and local affiliates across the country can strengthen your applications and implementation strategies around: Identifying the patients in need of devices and dataplans; Procuring, configuring and delivering devices to patients; Providing technical support to patients; Training your staff to perform some of these services Please contact me for more information and/or to be put in touch with NDIA affiliates in your community.

Chronic Illness & Specialty Care through Telemedicine?

Eva Minkoff

How is telemedicine now adapting to support those with chronic illnesses that are slightly more rare/difficult to diagnose? (i.e. autoimmune conditions, genetic joint conditions, pain conditions, etc.). How is telemedicine adapting to the Specialty physicians who typically treat them in person? (i.e. Rheumatologists, neurologists, gastroenterologists, endocrinologists, etc.)

Replies

Joseph Kvedar, MD (Expert)

the first thing to ask yourself is, "what data do I need to make a decision about diagnosis or management and can I obtain that data with the patient in a different location. if yes, you can perform your service by telehealth. lots of different options and use cases to digest.

RUSSELL LIBBY, MD (Expert)

There are many ways to answer that question and it reflects the technical sophistication and payment paradigms you work with.

The potential for more expert input, co-management, and better diagnostic and therapeutic choices is there, but is at the next level of telehealth than most are working in at this time. Payment that rewards outcomes and cost efficiency (value) and is convenient and appreciated by patients is the goal.

Are vital signs needed for telehealth G90439

Kimberly Hardy, MD

For G0438 and G0439 via telehealth -vital signs needed for reimbursement? When doing G0438 and G0439 via telemedicine - are the vital signs still a required piece? For G0438 is an eye exam still required for billing/reimbursement?

Telemedicine Data and Industry opinion

Jesse Cisneros

Telemedicine usage is skyrocketing given Covid-19 pandemic; what is the expectation once stay at home orders are lifted? Your data suggest a jump from 14% to 28% since 2016, my guess is that figure has jumped since patients who normally wouldn't consider telemedicine are now being forced to use adapt. Secondly, where can I find raw data pertaining to usage? By demographic, specialty and state level? Are there any cost/benefit studies out there?

Replies

Joseph Kvedar, MD (Expert)

my guess is that your data curiosity is ahead of what we have collected. Here is one non-scientific accounting of how things have skyrocketed. https://www.beckershospitalreview.com/telehealth/nyu-langone-providence-5-other-hospitals-experiencing-telehealth-surges.html

Marina Udowenko, MD

That will partly depend on the regulations and acceptance from government and insurers as far as whether telehealth will continue to be utilized as a main platform for health delivery. That being said, the technology side of the existing platforms is not ready for full telehealth visits. I have had experience using a few platforms, there are many key components missing, and the efficiency can also be improved to encompass a primary care/specialty visit.

DISCUSSION END