The Time Is Now: A Guide to Sustainable Telemedicine During COVID-19 and Beyond

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INTRODUCTION

Telemedicine, defined as "the application of information and communication technologies for providing healthcare services at a distance without the need for direct contact with the patient," was initially conceived as an opportunity for practices to reach more patients (1). Since the COVID-19 (Coronavirus disease 2019) pandemic, telemedicine has become a lifeline to practices seeking to maintain patient access to care and financial viability (2). Quite simply, telemedicine is "crossing the chasm" between being an interesting but rarely used technology to being essential (3,4). Physicians have at least the following 2 important questions: Should I keep telemedicine long term in my practice? What issues should I consider?

We outline important considerations on telemedicine, including licensing requirements, malpractice coverage, choice of platform, and reimbursement. This study not only serves to provide a roadmap for sustainable integration of telemedicine into gastroenterology (GI) practices and other specialties but also provides information on more acute issues surrounding the COVID-19 pandemic.

TELEMEDICINE IN CHRONIC DISEASE MANAGEMENT

Traditional healthcare is expensive for patients in several following ways that we rarely consider: transportation to-and-from visits, childcare expenses, lost time from work, and others (5). Telemedicine is especially useful to patients with chronic gastrointestinal conditions who typically require frequent visits. A recent randomized clinical trial enrolling patients with inflammatory bowel disease over a period of 1 year found that active patient monitoring over nurse-led telemedicine resulted in noninferior care and fewer hospitalizations, compared with standard in-person care alone (6). In hepatology, the Specialty Access Network-Extension of Community Healthcare Outcome program administered by the Veterans Health Administration suggested improved mortality among patients with liver disease by linking primary care providers directly with specialists remotely, compared with standard in-person care alone (7).

Learning the language of telemedicine and identifying the "key people in the room."

We outline important terminologies for physicians and other providers to understand the language of telemedicine and identify several key resources and stakeholders to help physicians stay up to date (Table 1). Frequently encountered terminologies include originating vs distant site, synchronous vs asynchronous care, and parity laws.

PERCEIVED BARRIERS TO USE

Does my medical license allow me to provide telemedicine?

In most states, the full professional medical license usually covers the ability to perform telemedicine visits with patients residing in your state. However, physicians may need to obtain a license in a neighboring state to see patients who are physically located in a neighboring state (see the Interstate Medical Licensure Compact [link: https://www.imlcc.org/] for expedited licensing). Many states now participate in interstate licensing for telemedicine, allowing expedited applications for licensure (8).

Does my malpractice coverage include telemedicine?

Malpractice coverage varies among insurance carriers; some carriers include this coverage, but others may need for you to add a rider or premium.

Will I be reimbursed?

The easiest way to work through your practice's reimbursement strategy is to break down your payer mix into the following 3 broad groups: Medicare, Medicaid, and commercially insured. Specific to traditional Medicare, coverage historically did not include the patient's home as an originating site and restricted telemedicine only to patients in a designated rural area, with the origin of telemedicine services at a clinic, hospital, or certain other type of medical facility (9). During the COVID-19 pandemic, Medicare dropped the originating site requirement enabling patients to receive care from home. Medicare advantage plans have traditionally offered more telemedicine reimbursement options than traditional Medicare, and some have no originating site requirement (10).

It is important to recognize that Medicaid plans are federally funded but state administered; thus, coverage varies by state. Fortunately, an increasing number of states are dropping originating site requirements.

For commercial insurance, there is significant heterogeneity in coverage, both between and within states. State-specific parity

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Table 1. Key terminology, concepts, and important resources to learn the language of telemedicine

Terms	Definitions and important considerations
Telemedicine	Typically refers to a real-time video connection with a patient to replace a traditional physicians' office visit
Telehealth	Includes a broader range of opportunities to communicate with patients using patient portals, phone calls, telemedicine, and other methods
Originating site	Where the patient is located during a telemedicine visit: (1) whether the patient is located at home or in a local physicians' office or other qualifying site (i.e., applicability of facility fees) and (2) the state in which the patient is located during the telemedicine visit (affecting licensing requirements)
Distant site	The state in which the gastroenterologist is located during a telemedicine visit (affecting licensing requirements)
Facility fee (in telemedicine)	If the patient is at home during a telemedicine visit, no facility fee is billed (only professional fees are billed by the telemedicine provider). If the patient is located at a qualifying originating site for a facility fee during a telemedicine visit, the typical charge structure involves the facility fee to cover the costs of the qualifying originating site and the professional fee for the telemedicine provider located at the distant site.
Synchronous care	Refers to any form of real-time telemedicine (by video or audio)
Store and forward (asynchronous care)	Includes secure email, images, videos, photographs, and other patient information that are typically used to communicate among providers. Eligible communications are sent electronically to another site for evaluation, outside of a real-time interaction (e.g., telespecialty care in areas without specialty care)
Parity law	State-specific law requiring commercial insurers to reimburse for telemedicine care *similarly* to in-person care, recognizing that these laws are often insufficient to ensure complete pay parity (reimbursement for a virtual visit at an equal rate as an in-office visit). (Link: https://www.cchpca.org/sites/default/files/2019-10/50%20State%20Telehalth%20Laws%20and%20Reibmursement%20Policies%20Report%20Fall%202019%20FINAL.pdf)
Consent	Requirements for telemedicine consent vary by state. Example consent forms are provided here: http://hub.americantelemed.org/thesource/resources/telemedicine-forms
American Telemedicine Association	A nonprofit professional organization whose mission is to encourage adoption of telehealth. (Link: https://www.americantelemed.org/)
Center for connected healthcare policy	A nonprofit foundation dedicated to integrating telehealth virtual technologies into the healthcare system. (Link: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies#)
Interstate medical license compact	Enables easier physician licensing application processes to provide telehealth in neighboring states within your catchment area. (Link: https://www.imlcc.org/)

laws ensure commercial insurance coverage for telemedicine services; however, providers should directly contact private payers to assess for restrictions and payment rates.

How common are technology problems for patients?

Availability of appropriate internet services and technological competence play a key role on the patient side. Especially in rural areas, internet access and speed may be a limiting factor. Similarly, some persons lack technological competence and are not able to use virtual communication platforms. Patients should be asked about such limitations before initiating a virtual encounter and to see whether there are any correctable actions that can be taken.

Is telemedicine appropriate for every patient?

Although COVID19 with its constraints forces us to defer face-to-face visits, virtual encounters have their limitations. As providers start offering telemedicine, they should consider the most appropriate target group(s) for such mediated encounters, start with them, and expand, as they gain experience and confidence.

Are there any special health information privacy concerns?

Privacy concerns matter, even if we are temporarily allowed to use less secure lines. Providers should be in closed rooms and should ask patients to use a location that does not allow others to overhear the conversation.

HOW DO I BILL AND CODE?

Although obvious, a physical examination is not required to bill successfully for telemedicine visits. However, you still need to meet the appropriate time-based (counseling) or evaluation- and management-based (complexity) requirements for billing as you already do in the office (11). It is also important to check local payer-specific requirements that may deny reimbursement for initial consults (new patient visits) using telemedicine. For example, before the COVID pandemic, traditional Medicare did not reimburse for new patient visits provided by telemedicine. Table 2 outlines the applicable Computerized Procedural Terminology billing codes for your standard telemedicine new and established patient visits across Medicare, Medicaid, and commercial insurers

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Table 2. Billing codes for new and established patient telemedicine visits are typically billed on time (at least 50% of which is spent in counseling)

New patient office/outpatient visit			Office consultation (new patient)			Established patient office/outpatient visit		
CPT code	Time requirement, min	wRVU	CPT code	Time requirement, min	wRVU	CPT code	Time requirement, min	wRVU
99201	10–19	0.48				99211	5–9	0.18
99202	20–29	0.93				99212[a]	10–14	0.48
99203	30–44	1.42	99243	40–59	N/A	99213[a]	15–24	0.97
99204	45–59	2.43	99244	60–79	N/A	99214[a]	25–39	1.50
99205	60	3.17	99245	80	N/A	99215	40	2.11

Consultation codes using evaluation/management billing can be used routinely if a virtual physical examination is performed. Refer to multisociety guidance for details on how to routinely document a virtual physical exam over video-based telemedicine (https://webfiles.gi.org/links/media/Joint_GI_Society_Virtual_Physical_Exam_Tips_Final_06052020.pdf).

Notice that the CPT codes listed are the same as are typically already used in the office. Please refer to Table 3 regarding modifiers which are necessary to denote that care was given by telemedicine. It remains important to verify the validity of these codes with your local commercial insurers and Medicaid plans (11,15).

CPT, Computerized Procedural Terminology; E/M, evaluation and management; wRVU, work relative value unit.

[a]99212 to 99214 can alternatively be billed on E/M without a virtual physical exam, rather than on time-based counseling, as long as the complexity requirements are met for (1) the history component and (2) the medical decision-making components, similar to standard in-person visits.

Adapted from ref. (14).

(Table 3 for review of commonly used modifiers; pay attention to your individual payer requirements).

Several other reimbursement mechanisms exist for ancillary telemedicine services you might consider, although coverage varies significantly among insurers. These mechanisms include G2012 and G2010 (virtual check-ins), 99421 to 99423 (e-visits), and 99358/99358 (prolonged non–face-to-face care). Table 3 adds important details for your practice manager to consider in designing your reimbursement strategy. The American College of Physicians provides a living document of telemedicine coding during the COVID pandemic (Link: https://www.acponline.org/practice-resources/covid-19-practice-management-resources/telehealth-coding-and-billing-during-covid-19).

CHOOSING A TELEMEDICINE PLATFORM

A variety of options are available for telemedicine services: see Table 4 for modalities that have been used by leaders of the ACG (*American College of Gastroenterology*) Practice Management Committee. Some electronic health record systems have embedded telemedicine platforms allowing for direct patient videoconferencing. Specific platforms devoted to telemedicine are also available. For example, Doxy.me is a telemedicine platform that provides services that span different provider types. Such platforms may allow providers in smaller practices access to telemedicine services they may not otherwise have had outside of tertiary care settings.

Recently, some platforms have evolved into a "virtual care model," in which audiovisual communication between patients

Table 3. Important considerations for practice managers on telemedicine billing

Considerations
Consultation codes are not recognized by Medicare but can be billed to some commercial insurers. These are generally automatically downcoded to "new patient office" codes when not recognized. Before using consultation codes routinely, consider the amount of time needed to use these codes. In many cases, reimbursement for 99205 will be greater than 99244 (and 99204 compared with 99243).
Place of service (POS) "02 – Telehealth" must be on the claim for Medicare. Some commercial insurers may require a different POS (such as 11) so that they recognize the visit in their existing system.
Modifier GQ (asynchronous telecommunications system) is required if the provider is affiliated with a federal telemedicine demonstration in Alaska or Hawaii.
Modifier 95 must be used on telemedicine claims for Medicare but check with commercial insurers on specific requirements (note that the GT modifier is still used by some commercial payers rather than modifier 95, noting that Medicare stopped recognizing the GT modifier when place of service 02 was released in 2017).
New patient codes cannot be billed on E/M services and must be billed on time because a physical examination cannot be performed. Established patient codes 99212 to 99214 can be billed on E/M service as long as history and medical decision-making complexity requirements are met.
The facility fee cannot be billed, unless the patient is physically located at the referring physician's office. The exception is that when a patient is seen at an originating site, the originating site may bill appropriate facility fees for its services to the patient as a separate bill (as part of normal, usual care in telemedicine).
Review documentation requirements to support telemedicine billing. You will need to document where the patient is located in your note. If billing on time, the time requirement should be stated.
Adapted from ref. (14).

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Table 4. Common telemedicine platforms for delivering gastroenterology care

Name	Information	Cost	Link
GI OnDEMAND[a]	• An ACG-endorsed member benefit • Includes secure video and end-to-end practice management tools such as scheduling, document sharing, EHR integration, and billing can be used by providers and patients on computers, laptops, tablets, and smartphones • Dedicated to practice of gastroenterology	Subscription and transactional models	https://giondemand.com/
Doxy.me (Doxy.me, LLC)	• Includes secure video • Telemedicine consent process built in	Free, or subscription model	https://doxy.me/
Epic (Epic systems corporation, Verona, WI)	• Built into the existing Epic EHR	Depends on your contract with EpicCare	https://www.epic.com/

EHR, electronic health record; GI, gastroenterology.
[a]GI OnDEMAND is a joint venture between American College of Gastroenterology and Gastro Girl, Inc. This table is adapted from ref. (14).

and providers is supplemented with a variety of other services. For example, a platform specific to GI providers supported by the American College of Gastroenterology (GI OnDEMAND) complements telemedicine services with disease specific educational materials and an online support community. There may be opportunities to integrate nutritional, psychological, and other services that may not always be available in traditional outpatient practice settings.

Whichever modality is chosen, the potential to depart from a set in-office schedule can allow providers more autonomy and flexibility regarding when they provide patient care. This can be potentially helpful to mitigate provider "burnout" (12).

Know and test your technology. Compared with phone calls, the visual connection may add to the value of an encounter by keeping communication partners engaged and by integrating nonverbal cues. In this context, providers should keep in mind that the 'face value' of the visual link may require facing the camera rather than the monitor.

CHANGES IN TELEMEDICINE POLICIES DURING COVID-19

The Centers for Medicare and Medicaid Services and an increasing number of state governors and medical boards reduced the burden on multistate licensing requirements for out-of-state providers and increased reimbursement and recognition for telemedicine services across insurance carriers. The Office for Civil Rights and the Department of Health and Human Services has stated that it will "not impose penalties for noncompliance with the Health Information Portability and Accountability Act Rules in connection with the good faith provision of telemedicine using such nonpublic facing audio or video communication products during the COVID-19 nationwide public health emergency" (13). Many of these reductions are tied to the ongoing state of emergency and may be temporary; thus, practices should start to "think long term" as they plan for continued telemedicine post-COVID.

CONCLUSIONS

We provided a roadmap for gastroenterologists and other specialists to understand the language of telemedicine. We also outlined particular considerations toward implementing telemedicine in practice. The ACG Practice Management Toolbox (link: http://webfiles.gi.org/docs/Toolbox/Essential_Guide_to_Telemedicine_in_Clinical_Practice.pdf) is a useful resource containing additional considerations including consent, practice policies, and scheduling processes in this rapidly expanding area of clinical care (14).

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CONFLICTS OF INTEREST

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