Editorial

Implementing Telemedicine in Response to the COVID-19 Pandemic

The 2020 COVID-19 pandemic has necessitated drastic measures nationally that impact the delivery of high quality urological care. Multiple municipalities and states have instituted shelter in place or stay at home policies wherein only essential workers, such as those in health care, may leave their residences. These policies have ramifications for patients who need more urgent urology care and for the panel of patients that urologists care for on a regular basis. In response to the pandemic Secretary of Health and Human Services Alex Azar has waived restrictions on telemedicine services for Medicare Part B beneficiaries retroactive to March 1, 2020 (1135 Waiver).[1] These changes allow Medicare patients to engage in video visits from any originating location, including their homes.[1] We provide an overview of the preexisting regulations and changes specific to the COVID-19 pandemic, provide platform resources for urologists[2] and offer pragmatic solutions to common telemedicine implementation concerns.

The imperative for most urology practices across the U.S. should be to convert almost all urology clinic visits to telemedicine visits or postpone the appointment. Most postoperative video visits can adequately replicate in-person postoperative visits. Most outpatient urology visits are not urgent. Yet maintaining urological care can ameliorate patient concerns that their health problems are being deferred and help offset an expected surge of patients who will certainly need care following resolution of the COVID-19 crisis. Performing video visits can also help reduce the financial strain on urology practices during this pandemic. Although many of the emergency provisions enacted during the crisis are temporary, their potential sustainability mandates consideration that urologists familiarize themselves with implementation of a telemedicine program that can continue after the pandemic is resolved.

TELEMEDICINE IMPLEMENTATION

Equipment

Prior to the pandemic all telemedicine platforms had to adhere to strict HIPAA (Health Insurance Portability and Accountability Act) compliant technical specifications. To maintain the safety of patients and health care workers, the emergency provisions allow for use of nonHIPAA-compliant platforms such as Facetime by Apple, Inc. However, urologists should prioritize use of a platform that is reliable and secure. Some platforms are embedded within the electronic medical record (EMR) and others are standalone software separate from the EMR. These include Zoom for Healthcare, Skype for Business, Doxy.me, Updox, VSee, and Google G Suite Hangouts Meet, all of which meet strict HIPAA compliance specifications. These platforms also contain a facile audio and visual component. These applications are device-agnostic, and can be used with a desktop, laptop, tablet computer or smartphone.

As long as a device has a microphone and a camera, it can be used for a telemedicine visit. These platforms also allow for multiple guest participants, through which providers can invite family members or language interpreters to join the encounter. There are 2 important reasons to prioritize HIPAA compliant platforms now. First, changes to federal law are superseded by state specific policies as some states may still require HIPAA compliant platforms for telemedicine visits. Second, urologists should prepare for some of the emergent changes to telemedicine policy to persist after the crisis abates. Appropriate telemedicine implementation today could ensure that rapidly scaled telemedicine programs are later sustained.

Legislative Considerations

The Center for Connected Health Policy (https://www.cchpca.org) is a resource for state specific laws and policies around telemedicine. They have updated this compendium to include emergency legislation during the COVID-19 crisis.[3] It is critical that health care providers conducting telemedicine visits familiarize themselves with their state policies surrounding video visits, including licensure requirements, need for consent documentation to conduct a video visit and prescription regulations. With the 1135 Waiver, Centers for Medicare and Medicaid Services are permitting interstate telemedicine for providers with an active

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nonrestricted medical license in another state.[4] Usually, for example, a provider licensed in Washington State is required to have medical licensure in Idaho to conduct telemedicine visits with Idaho residents. However, many states still mandate that providers submit an emergency application for credentialing.[5]

Coding

Telemedicine visits are billed similarly to in-person visits. A 15-minute in-person established patient visit and a 15-minute telehealth established patient visit are billed with Common Procedural Terminology (CPT) code 99213. The documentation of a telemedicine visit has important differences with in-person visit documentation. First, the treating health care provider should document patient consent to conduct a live face-to-face video conference visit. That documentation should also include the location of the treating provider as well as the patient location. The provider location is referred to as the distant site and the patient location is referred to as the originating site. Second, claims derived from the video visit should include a Place of Service = 02 or modifier code (ie GT or 95). These codes denote that a telemedicine encounter occurred and are typically required by private payers. Medicare does not require a modifier but the Place of Service = 02 must be denoted. Lastly, telemedicine encounters preclude a detailed physical examination. Higher level of service codes are difficult to achieve without a detailed physical exam. Therefore, most providers use time-based billing for telemedicine encounters.

Reimbursement for telemedicine encounters varies by payer. Historical restrictions that payers placed on patient location have largely been relaxed in recent years. Patients are no longer required to be located in a Healthcare Professional Shortage Area or conduct the video visit from an approved medical office. Medicaid does not specify the originating site location in 29 states and this is being rapidly expanded to address patient and provider safety during the COVID-19 pandemic.[3] Pursuant to the 1135 Waiver, Medicare allows the patient's home as the originating site for new and established patients during the COVID-19 pandemic.[1]

Logistical Concerns

Before conducting a video visit with a patient, we recommend a mock visit so that providers can familiarize themselves with the chosen video conferencing platform. The mock visit enables testing the various capabilities of the software, such as initiating a visit, terminating a visit, managing the audio and video functions, and screen sharing to demonstrate salient radiology findings or share relevant diagrams. The distant site for the encounter should be in a secure private location, such as a closed office. Be prepared to assist patients log in to the meeting, navigate audiovisual concerns and manage poor quality connections. In order to prevent some of these issues, our office staff contacts the patient at the time of appointment scheduling to deliver instructions for downloading any needed software, which is often supplemented with patient-centered telemedicine tip sheets.

TELEPHONE VISITS

A phone call may be necessary as not all patients have the required device for a video visit. Yet social distancing, and patient and health care worker welfare require consideration of telephone visits when telemedicine encounters simply are not feasible. Telephone visits are billable visits (CPT codes 99441-3) and must be accompanied by a visit time attestation. For Medicare beneficiaries, the documentation must be accompanied by the G2012 code. Several states have enacted emergency legislation that reimburses Medicaid telephone visits on par with telemedicine visits during the pandemic.[3] However, we recommend conducting telemedicine encounters when possible.

CONCLUSIONS

Urologists must prioritize the safety and well-being of their patients and their clinic workforce. Telemedicine optimizes both while we all attempt to navigate the COVID-19 state of emergency.

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