COVID-19 Telemedicine Implementation

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Learning Objectives

1. To provide broad practical guidance for rapid telemedicine implementation during a public health emergency
2. To give an approach to evaluation of existing resources that may be used for telehealth
3. To give an overview of IT considerations including hardware and different economical software options
4. To give an overview of clinical considerations including documentation and billing

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Tele- Terminology (Texas)

Telemedicine: Diagnosis and treatment, only physicians, PAs, and APNs

Telehealth: All other licensed health professional services

Telemonitoring: collected patient data is provided to a health care provider (often a physician or physician lead team) with health care decisions made based on that data

Live: interactive audio/visual connection with the patient

Store and Forward: static information is given to the provider who provides services without simultaneous interaction with the patient

The standard of care remains the same regardless of technology use.

Requirement	Covid19	Normal
HIPAA	"Enforcement discretion" but encourages warning & doesn't approve all services	Written acknowledgment prior to initiating treatment & private connection (BAA)
Consent	Waived via TMB, but best practice would be documentation of oral consent	Written consent prior to initiating treatment
Prescribing	Waived via DEA & TMN	Must have prior in person visit to prescribe scheduled drugs (DEA) & for chronic pain (TMB)
Technology: Medicare	Location requirements are waived via HHS Secretary (not all)	Live video & audio, with strict geographic, patient location, and provider requirements.
Medicaid & Private Pay (TDI)	Must pay same rate as in person for any allowed platform if a covered service	Must pay for video telemedicine if a covered service
Private Pay (ERISA)	Discretionary, but may cover things during this time	Discretionary

Links

HIPAA: https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

https://www.hhs.gov/sites/default/files/february-2020-hipaa-and-novel-coronavirus.pdf

TMB: http://www.tmb.state.tx.us/page/coronavirus

DEA: https://deadiversion.usdoj.gov/coronavirus.html

CMS: https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf

TDI: https://www.tdi.texas.gov/news/2020/coronavirus-updates.html

HHSC: https://hhs.texas.gov/services/health/coronavirus-covid-19/coronavirus-covid-19-provider-information

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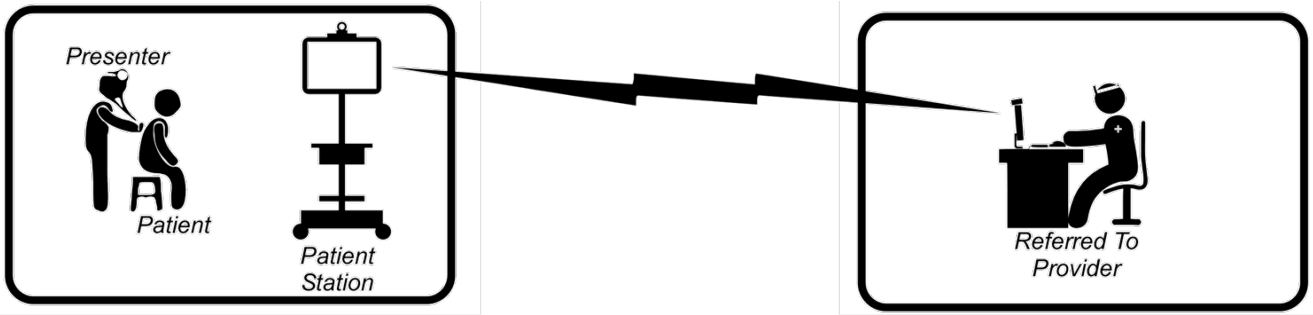
Telemedicine Technology Requirements

Synchronous Telemedicine

Patient to Specialist via Healthcare Presenter

- Typically includes presenter to work with patient and provider, vitals, EMR entry, operate medical cameras, electronic stethoscope, etc.
- More advanced issues can be addressed
- Presenters are the ‘hands’ of the Provider



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Synchronous Telemedicine

Direct Patient to Provider

- Typically web based
- No medical professional with patient to take vitals, information, etc.
- Primary issues are connectivity, HIPAA, lack of information

Asynchronous Telemedicine

- Radiology and DICOM Image Transfer
  - Images meet standards (2000 dpi)
  - HIPAA compliant
- EKG
  - Can be faxed or scanned and dumped into EMR
  - Dermatology
    - No standards
    - Can be standardized by using DICOM imaging technology

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Hybridized Telemedicine

Patient Monitoring Systems

- COPD, Diabetes, Cardiac issues, Sleep studies
- Needs patient compliance
- Patient has possession of technology, can lead to issues

Patient in Clinic with Presenter

Patient Cart

Patient Station

- Camera-12x zoom
- Monitor – HD, Medical Grade
- Cart – Medical Grade
- Medical Peripherals
  - Medical Camera
    - General View Lens
    - Otoscope
    - Dermascope
    - Anterior Chamber Lens
  - Stethoscope

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Provider Station

- Laptop or PC with HD Display
- I7 Quad Core Processor
- 8GB RAM
- 256GB SSD
- Built in Camera
- Speaker puck
- Headphones for stethoscope
- Video Conferencing Software

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Video Conferencing Software

- Zoom
- Starleaf
- Pexip
- Cisco Cloud Solutions
- Internal systems (Webex, Skype For Business)
- … and a whole lot of others…
- You are required to have a BAA with vendors when using their cloud based solutions.*** Current exception because of COVID 19 epidemic
- All systems should have Encryption
  - Consumer Skype is NOT HIPAA compliant and they won't sign a BAA

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Pitfalls to watch for

Network - Connectivity between locations should be already in place. If operating off of a grant, funds for networking connectivity (leased lines and connections) typically means when the grant ends, the project ends.

ITU Standards Compliance – This is desired. By systems being ITU compliant, they can communicate with other third-party systems. The most popular ITU videoconferencing formats are H.323, SIP and WebRTC based systems.

- Some vendors use terminology like “Secure Proprietary Video Conferencing”. Any system that follows ITU standards can be made secure by turning on encryption for all connections. Any proprietary system is going to tie users down to a single vendor solution.

Telehealth Peripherals – What specialties will the program be doing and are the peripherals directly related to those specialties? Or did a vendor load up a system in a quote for the program to ‘cover all bases’.

HIPAA Certified – There is no official HIPAA certification. HIPAA is a set of rules and expectations regarding PMI. Anyone who claims to be ‘certified’ is not being genuine.

Pitfalls

Closed Connectivity – Some vendors lock down their systems so users can only connect to their systems. Connecting to a third-party system is not allowed. This is a negative as it limits the expansion of the Telehealth network to other entities and requires purchases of vendor systems for any expansion.

- These vendors use terminology such as “Our Secure Network”, “Our Private Network”…
- Some vendors claim to allow connecting to other systems, but require a special piece of software or hardware access which is another charge added on, typically on a per-use basis.

Unnecessary Software Add-Ons – Vendors may load up systems with their EHRs, PACS viewers, Patient Uptake software, etc. as part of the package. They will add that they are capable of integrating with most institutional EHRs. Most institutions have existing software so this additional software is not necessary. Also integrating with EHRs, while possible, is time consuming and expensive.

Patient Equipment

"I have a fast computer. It's a little old"

" Yes, have a fast network connection"

Test connections if at all possible prior to appointment. You have no idea what their technology is and if it will work. And they probably don't either.

Patient Care Aspects of Telemedicine Implementation

Patient perspective

- Communication prior to initial telemedicine visit is key
- How telemedicine affects their care – reassure on quality
- How telemedicine differs – if no physical examination state that
- Reassure of temporary nature “hopefully by the time we have our next routine visit I will see you in person.”
- Communicate where you expect the patient to be when you contact them by phone or video conference
- Respect the scheduling – call when you said you would call

Maintain professionalism

- Particularly important if on video conference
- Adequate lighting
- Be aware of your background
- Appropriate clothing
- Rate and clarity of speech
- Pausing to let client/patient speak – especially for phone calls as no visual cues so ask frequently “Any questions or concerns?”
- Be transparent with any unavoidable issues with working from home unexpectedly

Documentation - 1

Write a protocol!

- Usual documentation of consent for telemedicine is waived
- Documentation detail affect billing in the same way as in person encounters
- Important: location of patient & providers, length of time of consultation
- Level 3 and 4 reimbursements must be based on time rather than physical examination

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Documentation -2

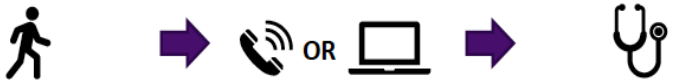
- Telemedicine provider assessments should include as applicable
  - Differential diagnosis
  - Active diagnosis
  - Prognosis and risk & risk reduction
  - Benefits of treatment
  - Instruction
  - Compliance/adherence
  - Coordination of care with other providers

Billing

- CMS has relaxed its usual telehealth billing rules
- In TX can bill for phone visits >> it does not mean that you will get paid (Medicare, private insurance)
- Office E&M codes can be used depending on documentation – e.g. 99213 or 99214 with the appropriate 95 telemedicine modifier

Billing Codes

Scenario 10 – (Non-COVID-19 case): Telehealth visit for a non-COVID-19 patient



Action	Communication method	Patient assessed: E/M telehealth, telephone assessment (*Flexibility: Permit audio only for E/M telehealth*)	
Who is performing		Physician / QHP	
Applicable CPT Code(s)	**Audio**	*New Patient: E/M Telehealth**	
	or	99201 99202 99203 99204 99205	
		*Established Patient: E/M Telehealth **OR** Telephone Evaluation (independent of E/M)**	
	Audio/Video	99212 (typical time 10 min)	99441 (5-10 min)
		99213 (typical time 15 min)	99442 (11-20 min)
		99214 (typical time 25 min)	99443 (21-30 min)
		99215 (typical time 40 min)	
Applicable ICD-10 codes		Report relevant ICD-10 code(s) related to reason for call or online interaction	
Place of Service		02 Telehealth	
Notes		*Payors may require the use of Modifier 95 for telehealth services	

Wellness: Patient & Provider

- Unprecedented stressful times for both patient and provider
- Consider screening for anxiety and depression
- Anxiety – GAD-2 >>>> GAD-7
- Depression – PHQ-2 >>> PHQ-9

Questions?