

# **Telemedicine Primer for Vascular Surgeons during the COVID-19 Pandemic**

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## **INTRODUCTION**

In the midst of the current national emergency, many hospitals and health care systems have cancelled all elective surgery and clinic visits in order to protect our patients, physicians, and staff as well as to prepare for an increased demand for hospital beds and ventilators given the exponential growth of coronavirus 2019 (COVID-19) cases in the United States and abroad. Given the impact of this pandemic on our lives and patient care, the Society for Vascular Surgery (SVS) Health Information Technology Task Force (HIT TF) recommends the implementation of telemedicine for patient encounters and teleconferencing services for professional interactions to optimize personal safety and continuity of patient care. Another reason of embracing telehealth is to reduce the personal protective equipment (PPE) and other resources consumed in face-to-face contact visits.

During the COVID-19 pandemic, SVS has prepared this primer on telemedicine to assist our members to safely provide uninterrupted medical and surgical care of our vascular patients. The mission of telemedicine is to improve patient access/experience, maintain high quality care, and reduce the cost of care across a population, which will ultimately improve the value of healthcare. According to the World Health Organization (WHO), telemedicine is the delivery of health care services using information and communications technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of healthcare providers, all in the interests of advancing the health of individuals and their communities, including synchronous, real-time audio and video communications, and asynchronous, store and forward interactions. The totality of the electronic communications must meet the key component and/or requirements of the same service when rendered via a face-to-face interaction. The use of interactive telecommunications equipment includes, at a minimum, audio and video telecommunications system.

## **PRIVACY AND IMPLEMENTATION**

Generally, technology compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) should be used for telehealth involving Protected Health Information (PHI) by entering into a business associate agreement (BAA) with the entity. The recent announcement

of telehealth expansion in response to COVID-19 is welcomed news for vascular surgeons to leverage virtual care. This crisis temporarily has encouraged the use of readily available digital platforms by any individual.

Many platforms allow for both synchronous interactions using real-time audio, video, or messaging and asynchronous “store and forward” transfers of medical records or images. By utilizing digital capabilities, we can mobilize the entire platform to virtual care, telemedicine, teleconference due to the current COVID-19 pandemic. On March 17, 2020, the Office for Civil Rights (OCR) at the Department of Health and Human Services (HHS) announced that they will not impose penalties for noncompliance with the regulatory requirements under HIPAA against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency.

[www.hhs.gov/hipaa/for-professionals/special-topics/...](http://www.hhs.gov/hipaa/for-professionals/special-topics/...)

According to the HHS.gov website, "A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients. OCR is exercising its enforcement discretion to not impose penalties for noncompliance with the HIPAA Rules in connection with the good faith provision of telehealth using such non-public facing audio or video communication products during the COVID-19 nationwide public health emergency. This exercise of discretion applies to telehealth provided for any reason, regardless of whether the telehealth service is related to the diagnosis and treatment of health conditions related to COVID-19. Under this notice, covered health care providers may use popular applications that allow for video chats, including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype, to provide telehealth without risk that OCR might seek to impose a penalty for noncompliance with the HIPAA Rules related to the good faith provision of telehealth during the COVID-19 nationwide public health emergency."

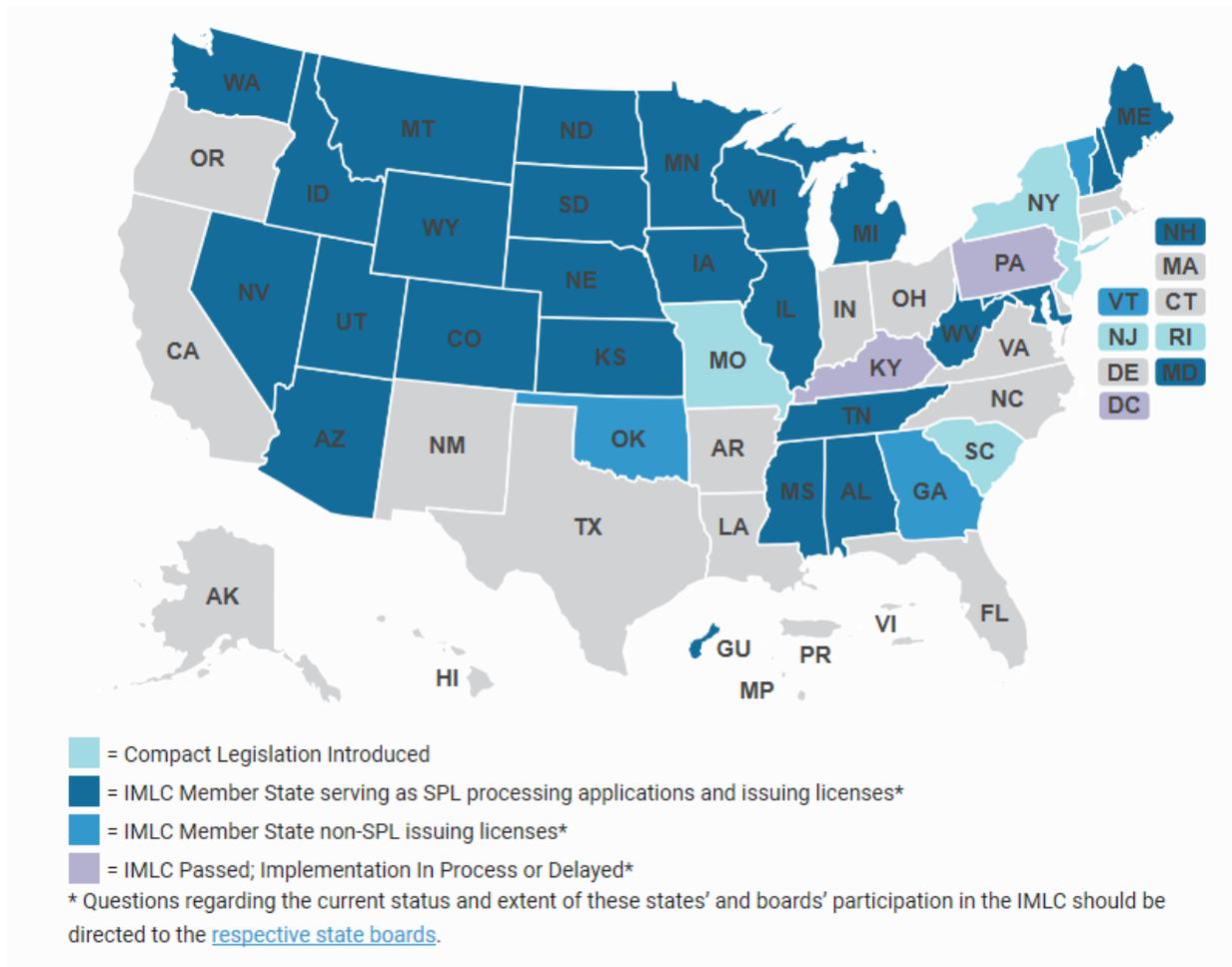
These HIPAA-compliant video communication products include:

- Doxy.me
- Google G Suite Hangouts Meet
- GoToMeeting
- InTouch Health
- Mend
- Mundaii
- Skype for Business
- swyMed
- Teladoc
- Updox
- VSee
- Zoom for Healthcare

As national and state policy is adjusting in response to the pandemic, it is important to closely follow updates to policy regarding privacy, coding, and reimbursement to provide optimal care to your patients via telehealth, while being aware that certain policy adjustments may be temporary. When uncertain, we recommend consulting with your institution's health IT department, compliance officer, healthcare compliance attorney, the [Centers for Medicare and Medicaid Services \(cms.gov\)](https://www.cms.gov), or the [U.S. Department of Health and Human Services \(hhs.gov\)](https://www.hhs.gov).

## **MEDICAL LICENSURE**

Telemedicine services must be provided by a physician or authorized practitioner. Telehealth services may be provided by hospitals, physicians, physicians assistants, nurse practitioners, psychologists, dietitians, and social workers. Prior to pandemic physicians had to have a license for each state they practice medicine including telemedicine. As telemedicine has become more utilized in the past several years, legislature to support its use across state lines has produced the [Interstate Medical Licensure Compact](#) (or IMLC). According to the website, the IMLCC is an agreement between 29 states, the District of Columbia and the Territory of Guam, where physicians are licensed by 43 different Medical and Osteopathic Boards. Under this agreement licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the agreed upon eligibility requirements. Approximately 80% of physicians meet the criteria for licensure through the IMLC. Physicians can qualify for licensing outside of their state of principle license through the IMLC. An online application process can be reached using the link above. Medicaid rules will depend on each state's rules. Private payers are individually determining expansion of their telehealth policy with regards to interstate care. **During the pandemic, CMS has waived the interstate licensing restriction allowing physicians to practice across state lines.**



## WORKFLOW AND PATIENT CARE

Clinical triage is important to determine protocols for appropriate patient selection for a telemedicine visit up front. The entire team should be trained including clinicians, care team members and schedulers. Patients should respond to a short survey or set of questions either electronically or over the phone prior to scheduling for proper triage. You should determine when telehealth visits will be available on the schedule (i.e. throughout the day intermixed with in-person visits or for a set block of time specifically devoted to virtual visits). To accommodate telehealth visits, a dedicated room can be an exam room or other quiet office space to have clear communication with patients. If multiple members of the care team will be helping to facilitate telehealth visits, ensure they know where to support the set-up of the technology and communicate with patients virtually. Let your patients know the practice is now offering telehealth services when they call the office. Have your office staff help support pro-active patient outreach. Have a plan for supporting patients on how to access telehealth visits based on your practice's technology and workflow to keep the clinic flow moving and avoid disruptions to care. Any time spent on testing audio and video connections prior to the scheduled telehealth visit will help ensure a successful experience for both the patient and the provider.

## **DOCUMENTATION**

Many electronic medical record (EMR) systems may be used for easier documentation for both telemedicine and traditional office visits. Despite relaxed policy on the use of telemedicine, proper documentation is still important. Written informed consent for the use of virtual visits should be obtained whenever possible. Verbal consent is allowed during this pandemic.

Be sure you are still properly documenting these visits – preferably in your existing EMR as you normally would with an in-person visit. This will keep the patient’s medical record together, allow for consistent procedures for ordering diagnostic testing, medications, etc. and support billing for telehealth visits. You should receive advanced consent from patients for telemedicine interactions. This should be documented in the patient’s record. Complete documentation should include:

1. The informed consent for using telehealth discussion. New patients should sign a written consent prior to the telehealth visit.
2. Statement that service was provided via telehealth, including the type of telehealth being utilized. The potential use of a non-HIPPA compliant technology should be mentioned, as well.
3. The location of the patient and provider.
4. The roles of people participating if not otherwise clearly stated.
5. Documentation to support appropriate coding.

An example to document an outpatient synchronous telemedicine note:

This is a telemedicine note. Patient was treated using telemedicine, real time audio and video, according to protocols. I, distant provider, conducted the visit from location identified below. The patient participated in the visit at a satellite location selected by the patient (or patient’s representative), identified below. I am licensed in the state where the patient stated they are located. The patient (or patient’s representative) stated that they understood and accepted the privacy and security risks to their information at their location.

Patient was located at \*\*\* city, state

I, distant provider, was located at \*\*\* city, state

To document telemedicine visits occurring in place of an office visit during the pandemic, proper documentation is still vital. An example of this documentation is as follows:

This visit has been changed from an in-person office visit to a video visit to lower the risk of exposure and/or spread of the current pandemic with the SARS CoV-2 virus. This is based on guidelines from the CDC and other health agencies. The patient is located at \*\*\* city, state. The remote physician is located at \*\*\* city, state.

## **CODING AND REIMBURSEMENT**

Centers for Medicare and Medicaid Services (CMS) defines synchronous telemedicine service as a real-time interaction between a physician or qualified health care professional and a patient

who is located at a distant site. Although telemedicine has been growing at a steady pace, the surgical specialty fields have been slow to adopt the paradigm. Previously, our group has demonstrated the feasibility of synchronous telemedicine visits, non-inferiority of clinical outcomes, and their efficacy with regards to time savings, distance traveled, and greenhouse emission. From the patient’s perspective, access to virtual care services seems efficient and improves satisfaction. Yet, from the provider’s perspective, one major barrier to adoption is the concern for lack of reimbursement for telemedicine visits. A recent study showed that states with parity laws saw significant increases in the utilization of outpatient telehealth visits; the odds of receiving a telehealth visits in a parity state were 29.8% greater than in a non-parity state from 2010-2015. In addition, telemedicine reimbursement coverage varies greatly across parity states.

As of March 6, 2020, CMS will temporarily provide coverage for telehealth services throughout the country for the duration of the COVID-19 pandemic. The expanded benefits will allow greater flexibility for providers and patients utilizing this critical tool to care for patients remotely. Prior to this expansion, telehealth services were only covered for patients receiving services in rural or remote locations and they were not allowed to receive the telehealth service from their home. Patients are now able to receive telehealth services in any healthcare facility, including a physician office, skilled nursing facilities, and in the home. For more information, visit the [Medicare Telemedicine Health Care Provider Fact Sheet](#).

Medicaid laws are state-dependent but already provide a varying degree of flexibility to states regarding telehealth. The Center for Connected Health Policy, a non-profit organization focused on national telehealth policy, has created an up-to-date resource for [State Telehealth Laws](#). At the current time, California is the only state to enact a law to remove barriers to telehealth during the current pandemic.

Private payers are starting to follow suit with CMS. Large commercial insurers, such as Aetna, BlueCross Blue Shield, Cigna, Humana, UnitedHealthcare and more are moving to expand telehealth coverage. For some, it is expressed that these policy changes may become permanent, even after the current public health crisis has resolved. Regardless of coverage, receiving and providing telehealth medicine is not prohibited. Rather, the controversy lies in its reimbursement and coverage.

*New Patients.* CPT Codes 99201-99205 for new patients, POS 02 for Telehealth Medicare and modifier 95 for Commercial Payers

CPT Code	RVU	Minutes
99201	0.48	10
99202	0.93	20
99203	1.42	30
99204	2.43	45

99205	3.17	60
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*Established Patients.* CPT Codes 99211-99215 for established patients, POS 02 for Telehealth Medicare and modifier 95 for Commercial Payers.

CPT Code	RVU	Minutes
99211	0.18	5
99212	0.48	10
99213	0.97	15
99214	1.50	25
99215	2.11	40

### New CMS 2020 Code Updates

*Online Digital Visits.* CPT Codes 99421-99423. Patient-initiated online digital evaluation and management service provided by qualified **physician** health care professional.

CPT Codes	Description
99421	For up to 7 days cumulative time during the 7 days; 5-10 minutes
99422	For up to 7 days cumulative time during the 7 days; 11-20 minutes
99423	For up to 7 days cumulative time during the 7 days; 21 or more minutes

*Online Digital Visits.* CPT Codes 98970-98972. Patient-initiated online digital evaluation and management service provided by qualified **nonphysician** health care professional.

CPT Codes	Description
98970	For up to 7 days cumulative time during the 7 days; 5-10 minutes
98971	For up to 7 days cumulative time during the 7 days; 11-20 minutes
98972	For up to 7 days cumulative time during the 7 days; 21 or more minutes

*Remote Patient Monitoring.* CPT Codes 99453-99454, 99457-99458, 99091. Collecting and interpreting physiologic data digitally stored and/or caregiver to the physician or qualified health care professional.

CPT Codes	Description
99453	Remote monitoring of physiologic parameters, initial; set-up and patient education on use of equipment
99454	Devices supply with daily recordings or programmed alerts transmission, Each 30 days
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar

	month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99458	Each additional 20 minutes
99091	Collection and interpretation of physiologic data digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation

*Telephone Evaluation and Management Service.* CPT Codes to describe telephone evaluation and management services available since 2008, which are NOT covered by Medicare. Some private payers may pay for these services.

CPT Codes	Description
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	11-20 minutes of medical discussion
99443	21-30 minutes of medical discussion

Given that the current reimbursement policy surrounding telemedicine was cited as a barrier for the adoption of this care model, we analyzed the total reimbursement and breakdown of payments for telemedicine outpatient management in an integrated healthcare system in Michigan, which enacted State Parity Law in 2012. During the study period, payors included Aetna US Healthcare, Blue Advantage, Blue Cross Blue Shield, Cofinity Plan, Health Alliance Plan, HAP Medicare Advantage, Humana Medicare Advantage, Medicaid, Medicare, Molina Medicaid HMO, United Healthcare, Blue Care Network, Aetna Better Health of Michigan, Priority Health, and self-pay. Among the 184 virtual visits, a grand total of \$22,145.00 was billed for an average of \$120.35 per virtual encounter. The breakdown of charges billed was \$8,879.33 (40%) adjusted, \$9,158.45 (41%) paid by insurance, \$2,317.52 (10%) paid by patient, and \$2,900.11 (13%) denied. After rebilling, there were 8 denials (4%) resulting in lost revenue. Average out-of-pocket cost to patients was \$20.46 per visit. Majority of the telemedicine encounters for new consultations and return visits were coded as level of service 3 or 4. Post-operative visits within the global period were charged appropriately as the same as in-person visit. Up to date, 51% of all charges billed have been received. Insurance payments ranged from 0% to 67% of charges billed, depending on the insurance program. Median was 37% and average of 35% billed. Analysis of 27 denied payment (15%) showed that the true denial payments occurred in a minority of cases: 8 true denials (4%). The other denials were readjusted in payment for other services, such as during the postoperative global period.

## ADVANTAGES AND BARRIERS

Besides the barriers related to cost and insurance status, other barriers may include lack of available appointment times, off-hours healthcare needs, transportation barriers, technical barriers (lack of internet access or no access to computers and smartphones), time off work, and lack of specialists or physicians nearby. Virtual innovation around the country showed that 77% of American own a smartphone, and 66% of Americans are willing to see a doctor via video. Due to the availability of smartphones and growing acceptance by American patients for virtual visits, virtual care technology is gaining traction as a viable healthcare delivery platform in the United States.

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