Telehealth: What Clinicians Need to Know

Maine AAP Fall Webinar Series

October 23, 2025

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Objectives

1. Review current AAP member surveys re: telemedicine
2. Share key Telemedicine Policies updates
3. Broadband access, successes and challenges
4. Review Data regarding Telemedicine Value and Effectiveness

In Loving Memory of Dr Janice Pelletier- Co-creator of ME AAP Telehealth committee

10/23/22

Key Points to be Discussed

Telemedicine

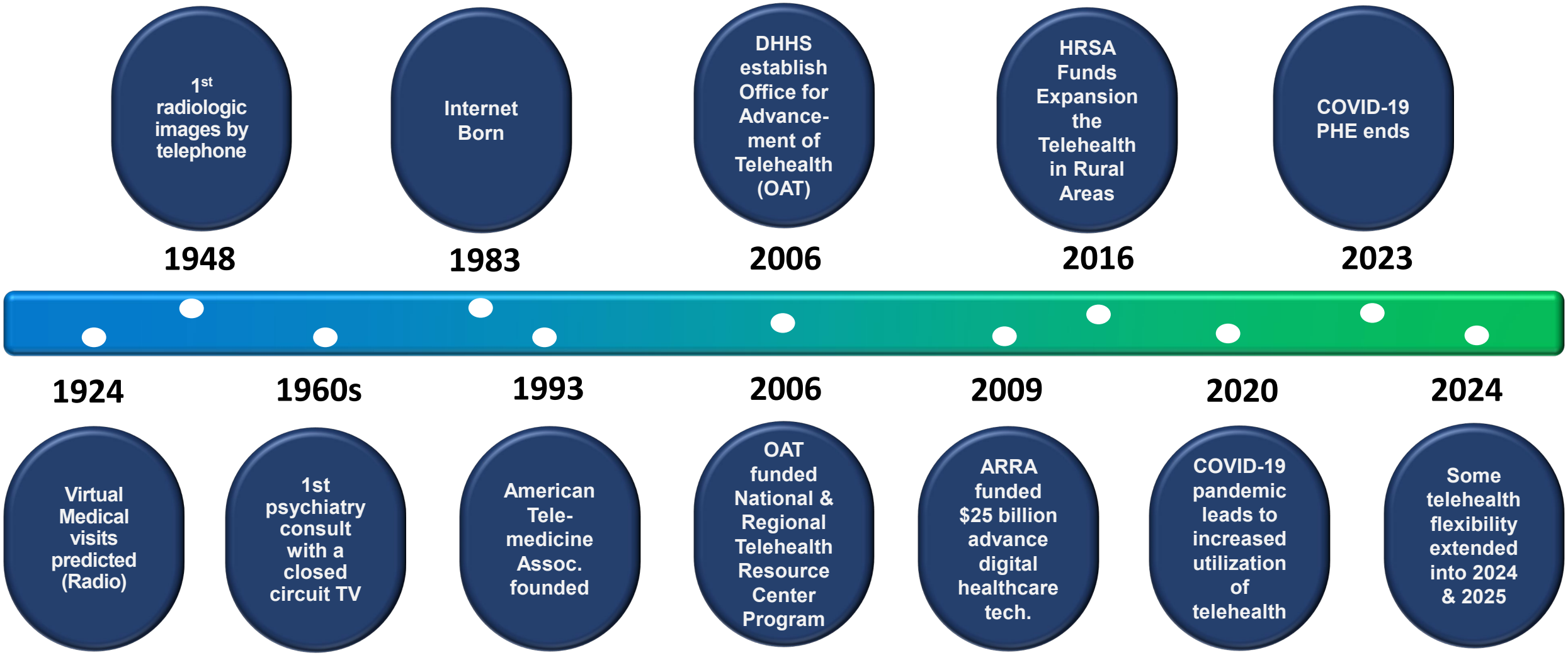
- Current status
- Barriers
- Challenges/Risks
- Advantages

Value, Access & Equity

Gaps

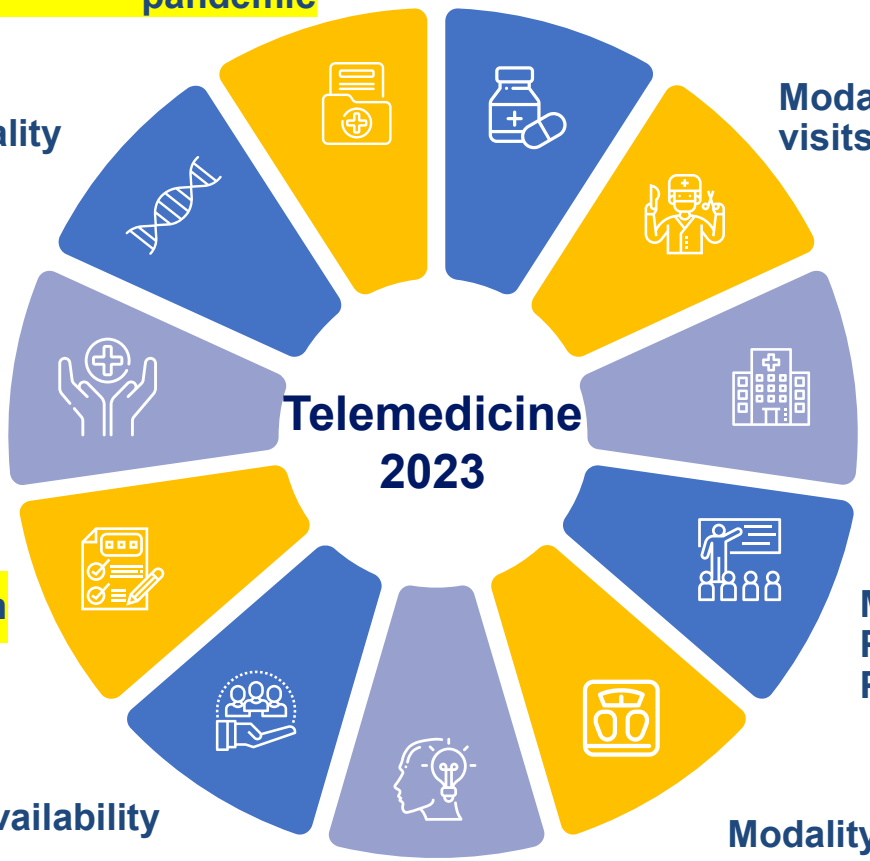
Opportunities

The Evolution of Telemedicine



Source: Upper Midwest Telehealth Resource Center (https://www.umtrc.org/clientuploads/UMTRC%20Resource%20PDF/Updated_Telehealth_and_Telemedicine_Timeline.pdf) with permission

Where are we currently in Telemedicine?



Vast expansion pre/post pandemic

Growth of modalities

Confidentiality

Modality Growth: Video visits, telephonic

Extension of policies

Modality Growth: e-consults, remote patient monitoring

Patient satisfaction

Modality Growth: Message Portals, Provider to Provider consultation

Patient availability

Modality Growth: mHealth apps, synchronous & asynchronous

Provider Efficiency

O'Malley G, Shaikh W, Marcin J. Telehealth and patient safety. Agency for Healthcare Research and Quality. https://psnet.ahrq.gov/primer/telehealth-and-patient-safety
O'Hara, V.M., Louder, D., Johnston, S.V. *et al.* Pediatric Obesity Care via Telemedicine: Expanding the Path Forward—A Review. *Curr Obes Rep* (2023). https://doi.org/10.1007/s13679-023-00537-w

ME AAP Telehealth Survey

Sent out with summary **November 2023**

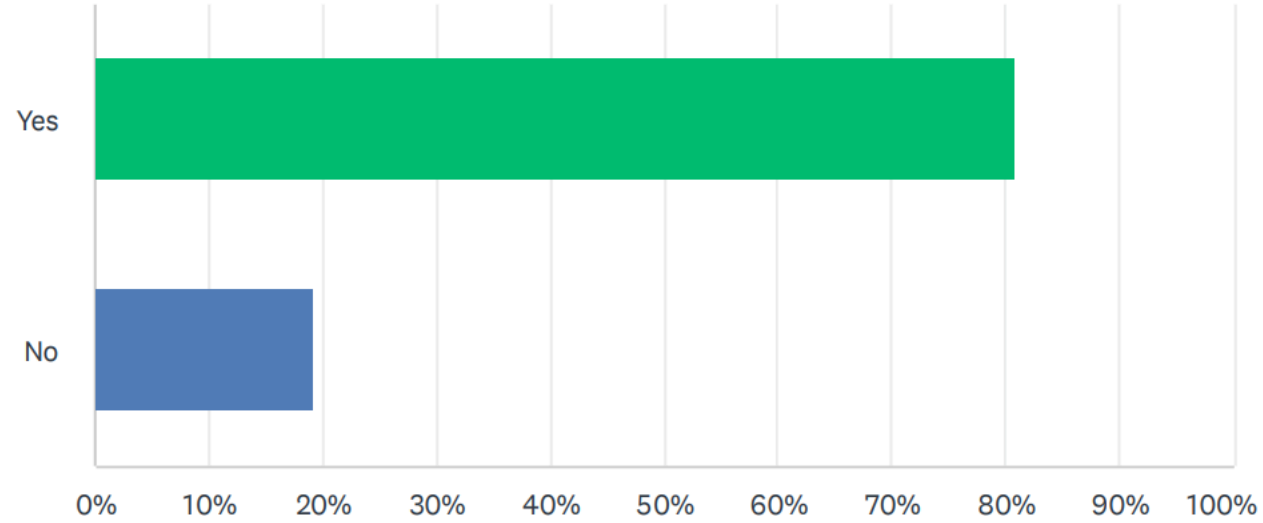
26 respondents

10 Question Survey

Provider Input on Telehealth Survey_November 2023

Q1 Are you currently using telehealth in your practice?

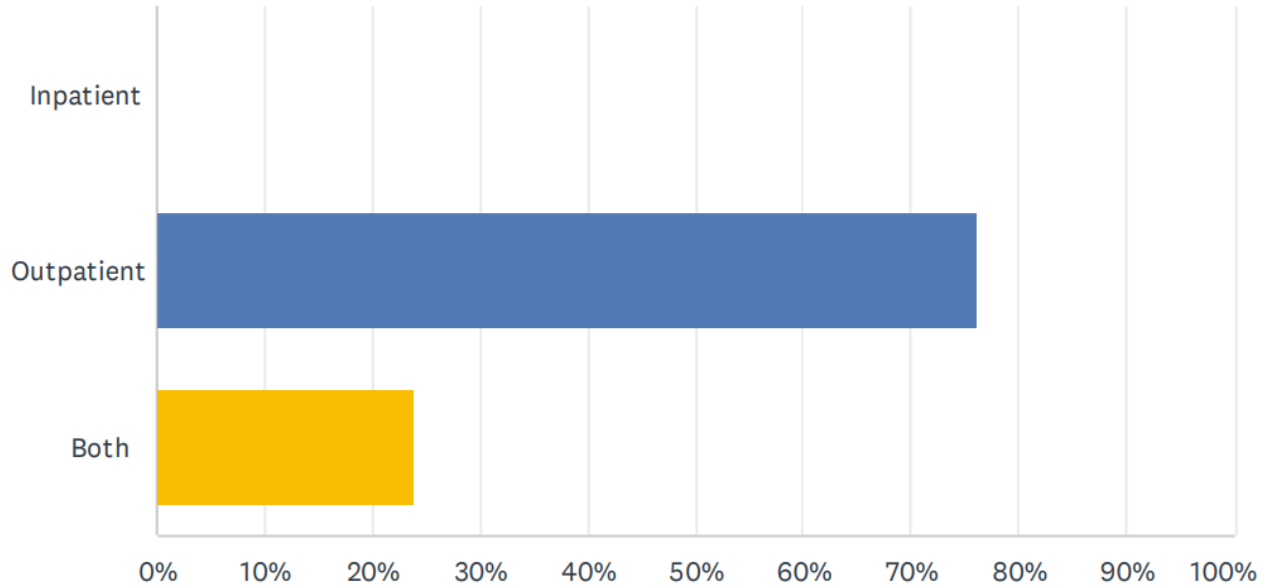
Answered: 26 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	80.77%	21
No	19.23%	5
TOTAL		26

Q2 If yes, are you using telehealth for inpatient care, outpatient care or both?

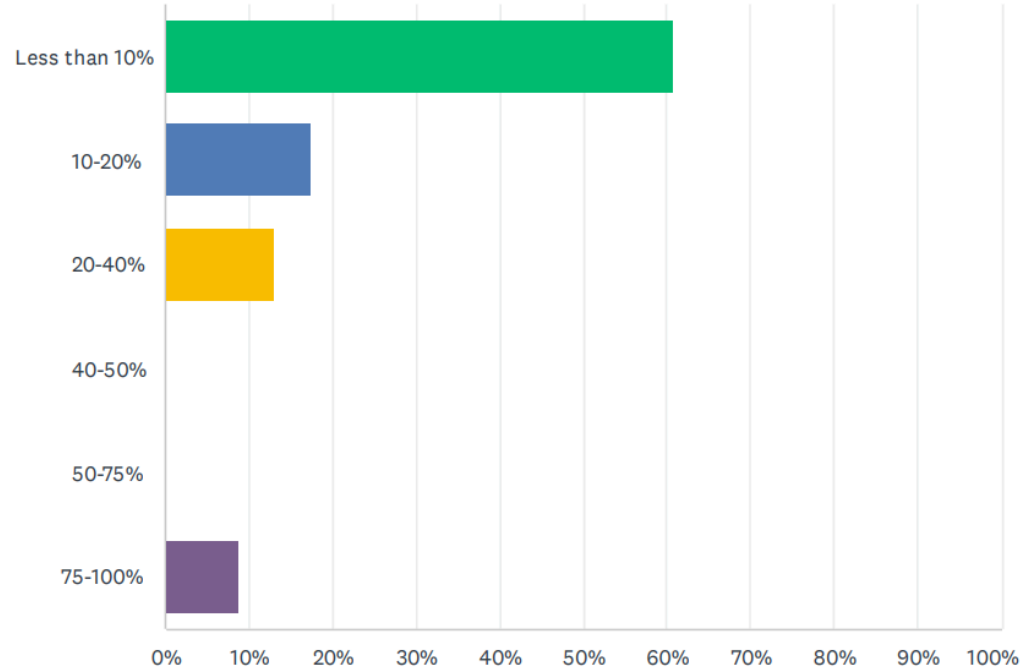
Answered: 21 Skipped: 5



ANSWER CHOICES	RESPONSES	
Inpatient	0.00%	0
Outpatient	76.19%	16
Both	23.81%	5
TOTAL		21

Q4 If yes, approximately what percentage of your visits are via telehealth?

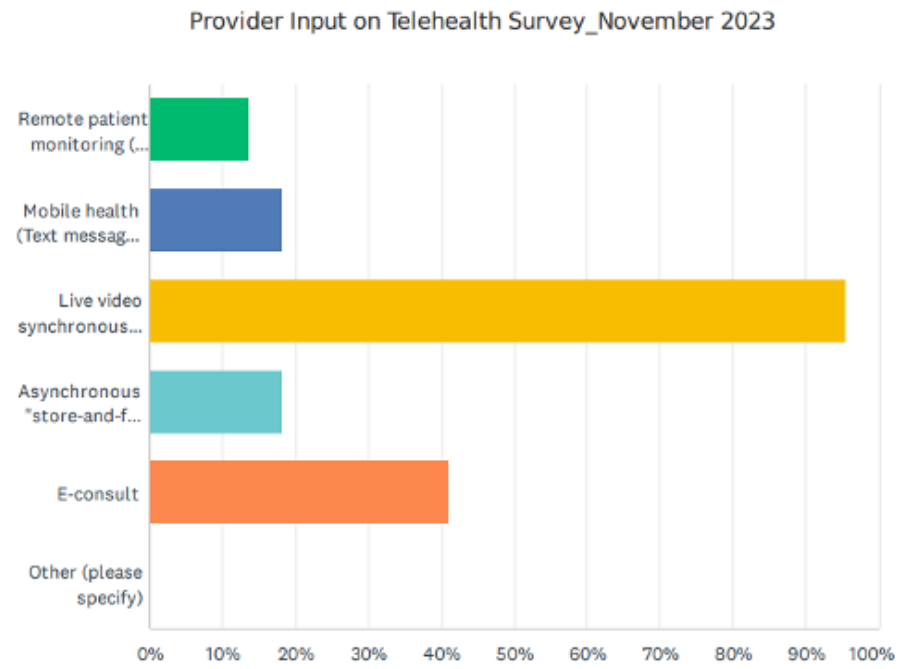
Answered: 23 Skipped: 3



ANSWER CHOICES	RESPONSES	
Less than 10%	60.87%	14
10-20%	17.39%	4
20-40%	13.04%	3
40-50%	0.00%	0
50-75%	0.00%	0
75-100%	8.70%	2
TOTAL		23

Q5 What type of telehealth are you using? (select all that apply)

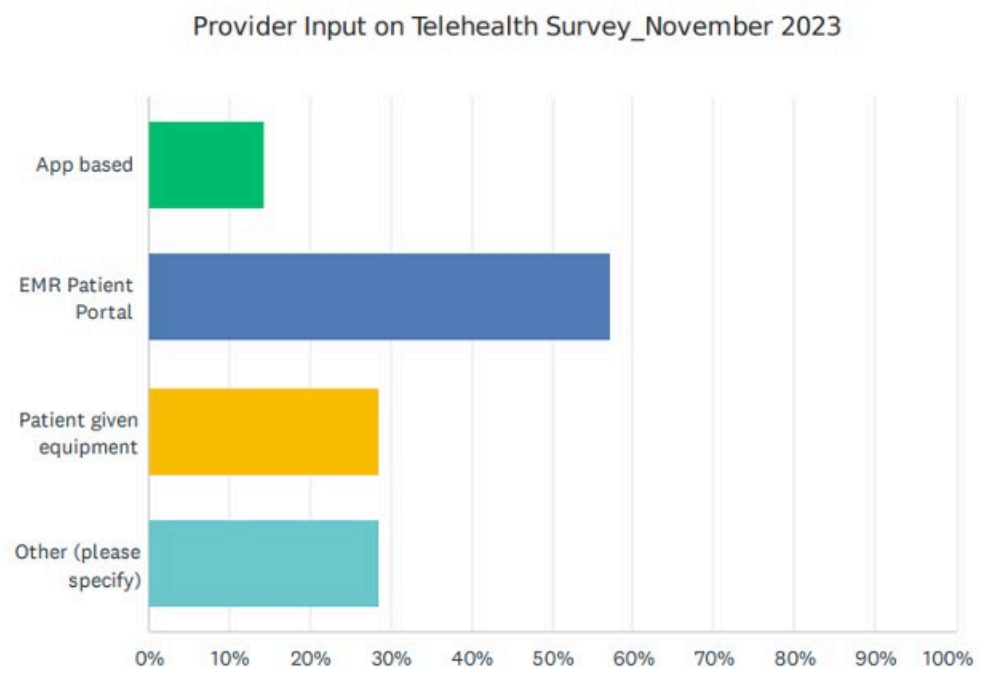
Answered: 22 Skipped: 4



ANSWER CHOICES	RESPONSES	
Remote patient monitoring (App based, EMR Patient Portal, Patient given equipment, etc)	13.64%	3
Mobile health (Text messages to patients, Patient scheduled online appointments, etc.)	18.18%	4
Live video synchronous telehealth visits	95.45%	21
Asynchronous "store-and-forward" approach where the patient shares information through a patient portal and the provider reviews it later (e.g., digital photography of a lesion).	18.18%	4
E-consult	40.91%	9
Other (please specify)	0.00%	0
Total Respondents: 22		

Q6 If you selected Remote Patient Monitoring in question 4, please select the methods used to record data. (select all that apply)

Answered: 7 Skipped: 19

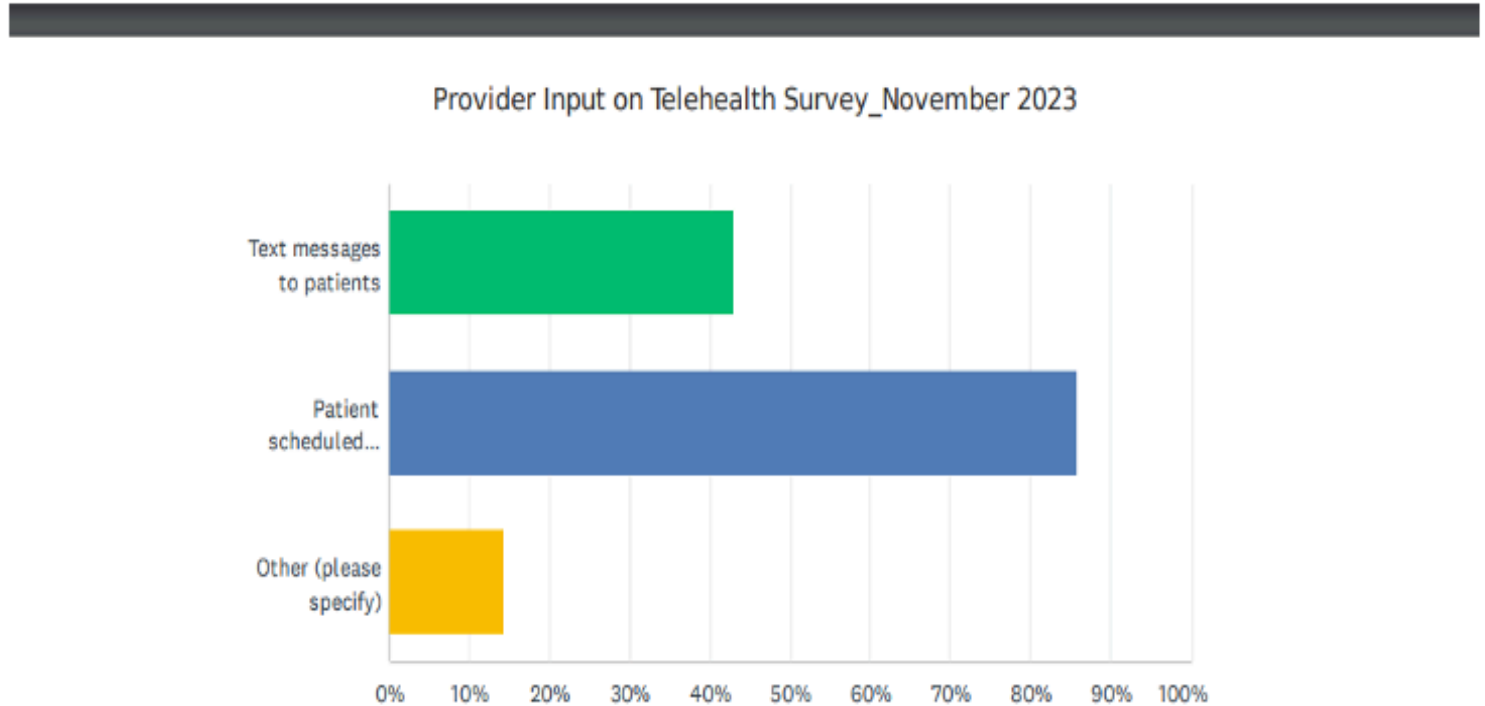


ANSWER CHOICES	RESPONSES	
App based	14.29%	1
EMR Patient Portal	57.14%	4
Patient given equipment	28.57%	2
Other (please specify)	28.57%	2
Total Respondents: 7		

We use remote sitters for eating disorder patients in the hospital during meal times.

Q7 If you selected Mobile Health in question 4, please select the methods used. (select all that apply)

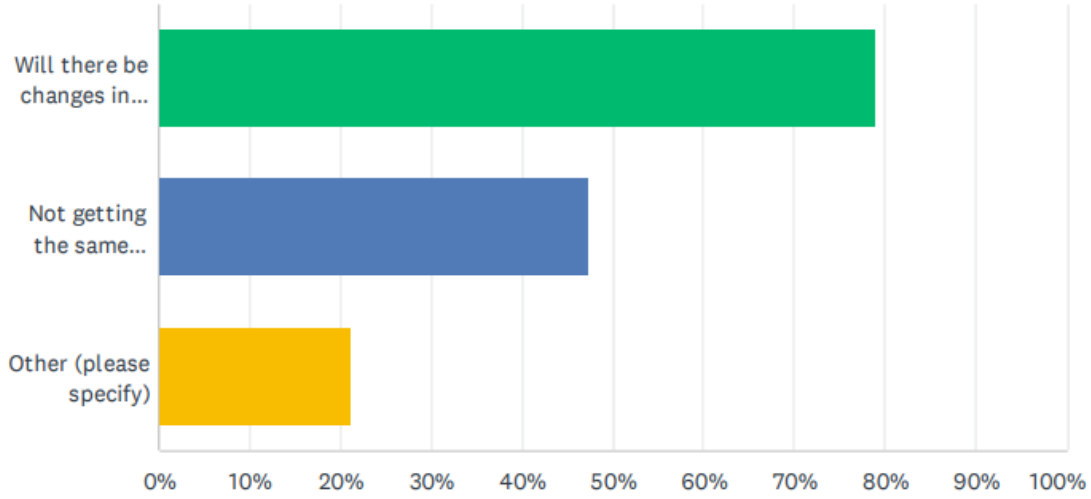
Answered: 7 Skipped: 19



ANSWER CHOICES	RESPONSES	
Text messages to patients	42.86%	3
Patient scheduled online appointments	85.71%	6
Other (please specify)	14.29%	1
Total Respondents: 7		

Q8 What, if any, ongoing questions do you have regarding telehealth? (select all that apply)

Answered: 19 Skipped: 7



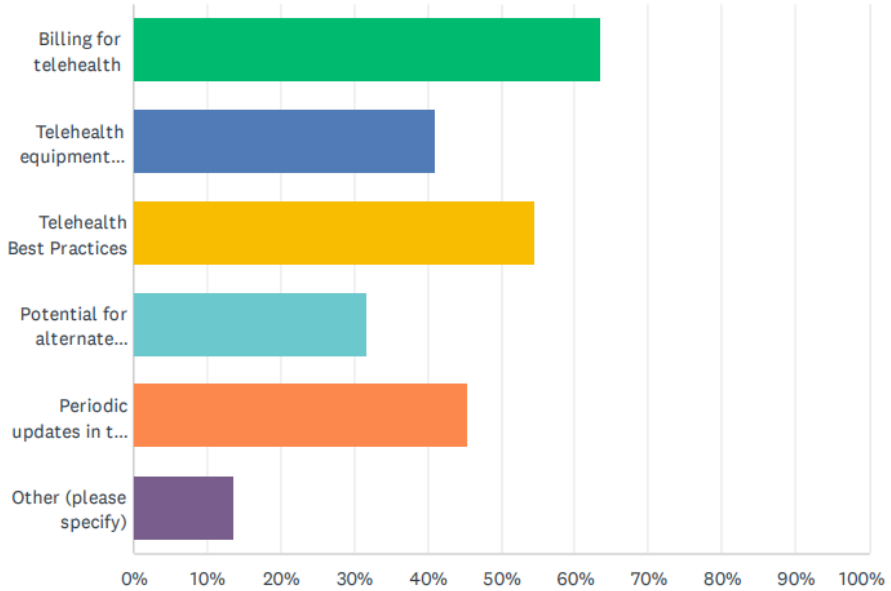
Provider Input on Telehealth Survey_November 2023

ANSWER CHOICES	RESPONSES	
Will there be changes in reimbursement in this post-COVID period	78.95%	15
Not getting the same reimbursement for telehealth as opposed to face-to-face post-COVID period (e.g., facilities fee)	47.37%	9
Other (please specify)	21.05%	4
Total Respondents: 19		

#	OTHER (PLEASE SPECIFY)	DATE
1	How to advance our federal laws to allow us to provide Telehealth visits with established kids or college students who are out of state (like at college).	11/29/2023 9:52 PM
2	none	11/29/2023 12:17 PM
3	Telehealth if patient is in college outside of maine	11/29/2023 12:05 PM
4	How will quality of care/ outcomes for telehealth be mead?	11/8/2023 4:06 PM

Q10 Telehealth InterestsI would be interested in learning more about (select all that apply):

Answered: 22 Skipped: 4



Provider Input on Telehealth Survey_November 2023

ANSWER CHOICES	RESPONSES	
Billing for telehealth	63.64%	14
Telehealth equipment (e.g., Incentive Spirometry)	40.91%	9
Telehealth Best Practices	54.55%	12
Potential for alternate funding and other opportunities for telehealth	31.82%	7
Periodic updates in the newsletter (Maine AAP)	45.45%	10
Other (please specify)	13.64%	3
Total Respondents: 22		

#	OTHER (PLEASE SPECIFY)	DATE
1	I'm particularly interested in seeing if home otoscopes could reduce UC/ER visits for nighttime ear pain and if home stethoscopes are sensitive enough to reduce ER/UC visits for asthma/breathing concerns. For certain populations, I would love to know if insurance would reimburse for home devices given cost savings of reduced high cost visit.s	12/5/2023 8:15 PM
2	none	11/29/2023 12:17 PM
3	other types of digital health services and how to address workforce and quality gaps	11/9/2023 11:40 AM

POLICY

Telehealth Policy Changes after Public Health Emergency

Permanent Medicare changes

- FQHCs & RHCs can serve as a distant site provider for behavioral/mental telehealth services
- Medicare patients can receive telehealth services for behavioral/mental health care in their home
- No geographic restrictions for originating site for behavioral/mental telehealth services
- Behavioral/mental telehealth services can be delivered using audio-only communication platforms
- RHCs are eligible originating sites for telehealth

Temporary Medicare changes to 12/31/24

- FQHCs and RHCs can serve as a distant site provider for non-behavioral/mental telehealth services
- Medicare patients can receive telehealth services in their home
- No geographic restrictions for originating site for non-behavioral/mental telehealth services
- Some non-behavioral/mental telehealth services can be delivered using audio-only communication platforms
- An in-person visit within six months of an initial behavioral/mental telehealth service, and annually thereafter, is not required
- Telehealth services can be provided by all eligible Medicare providers

Consolidated Appropriations Act, 2023
https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency

CMS-Medicare

COVID-19 POLICY	ENDS W/PHE	EXPIRES DEC 31, 2023	EXPIRES DEC 31, 2024	MADE PERMANENT
Suspended location requirements (geographic & site)			X	
Temporarily allowed audio-only to be used for some services			X	
Allows all eligible Medicare providers to use telehealth to deliver services (Including FQHCs & RHCs) *			X	
Some services temporarily allowed to be provided via telehealth		X (2024 PFS)	X	
Suspend in-person visit requirement prior to providing services via mental health if not trying to meet location requirements			X	

CMS Fact Sheets

CMS-Medicare

COVID-19 POLICY	ENDS W/PHE	EXPIRES DEC 31, 2023	EXPIRES DEC 31, 2024	MADE PERMANENT
Allow remote evaluations, virtual check-ins and e-visits to be provided to new and established patients	X (for established only)			
Allow remote physiological monitoring services to be furnished to new and established patients	X (for established only)			
Subsequent SNF visit could be furnished via telehealth w/o limitation	X (now once every 14 days)			
Flexibilities to Stark Laws	X			
HHA may provide more services to beneficiaries using telecommunications technology within the 30-day care period as long as it's part of the patient's plan of care and does not replace needed in-person visits				X

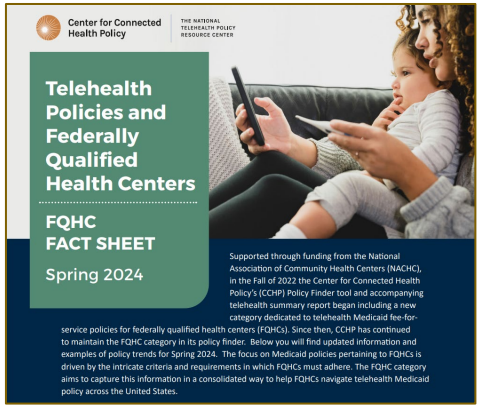
CMS Fact Sheets

CMS-Medicare

COVID-19 POLICY	ENDS W/PHE	EXPIRES DEC 31, 2023	EXPIRES DEC 31, 2024	MADE PERMANENT
When a physician or nonphysician practitioner, who typically furnishes professional services in the hospital outpatient department, furnishes telehealth services to the patient's home during the COVID-19 PHE as a "distant site" practitioner, they bill with a hospital outpatient place of service, since that is likely where the services would have been furnished if not for the COVID19 PHE. The hospital may bill under the OPPS for the originating site facility fee associated with the telehealth service.	X			
During PHE Providers are allowed to provide services via telehealth from their homes without reporting the home address during enrollment.		X	Extended through 12/31/24 PFS '25 would extend again	

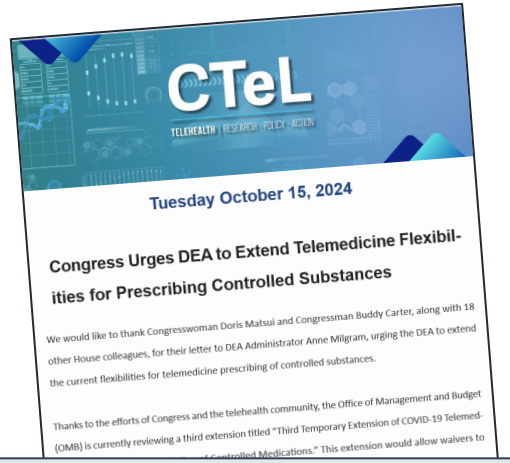
CMS Fact Sheets

Moving Forward – Policy Change



Permanent and Proposed Expansion of State TH Rules/Laws

[ATA EDGE's 118th Congress Legislative Tracker]



Track [Federal] & [State] Legislation on CCHP's Website!

Telehealth Modernization Act of 2024 ([HR 7623, S.3967]) - would make permanent a majority of the Medicare flexibilities implemented during the COVID-19 Public Health Emergency.

[CONNECT for Health Act] – removes long-standing barriers to telehealth and promotes program integrity. See CCHP Fact Sheet.

Advancing Access to Telehealth Act ([HR 7711]) amend title XVIII of the Social Security Act to make permanent certain telehealth flexibilities under the Medicare program

Key Takeaways – CY 2025 PFS Proposed Rule

Telehealth: CMS maintains it has limited statutory authority to extend most Medicare telehealth policies. Without congressional action, the significant Medicare telehealth waivers will expire on December 31, 2024, and return to pre-COVID-19-public-health-emergency (PHE) policies.

- **Two-way real-time audio-only communication technology** for any telehealth service furnished to a patient in their home if the patient is not capable of, or does not consent to, the use of video technology. (1) the home must be a permissible originating site; (2) the distant-site practitioner has to be capable of using an interactive audio-visual system; and (3) the patient must not be capable of or not consent to the use of video technology. Modifier 93 has to be appended to the claim for services to verify that these conditions have been met.
- **Distant Site Requirements:** CMS proposes to permit distant site practitioners to continue reporting their currently enrolled practice location instead of their home address when providing telehealth services from their home through CY 2025.
- **Direct Supervision-Proposed** to extend through December 31, 2025: physician/practitioner to be considered "immediately available" through virtual presence using two-way, real-time audio/visual technology for certain services. Proposes to permanently adopt a definition of direct supervision that allows" immediate availability" as described above for a subset of incident-to-services (mainly services typically performed in their entirety by auxiliary personnel, (technical and professional component of "5" and CPT code 99211).

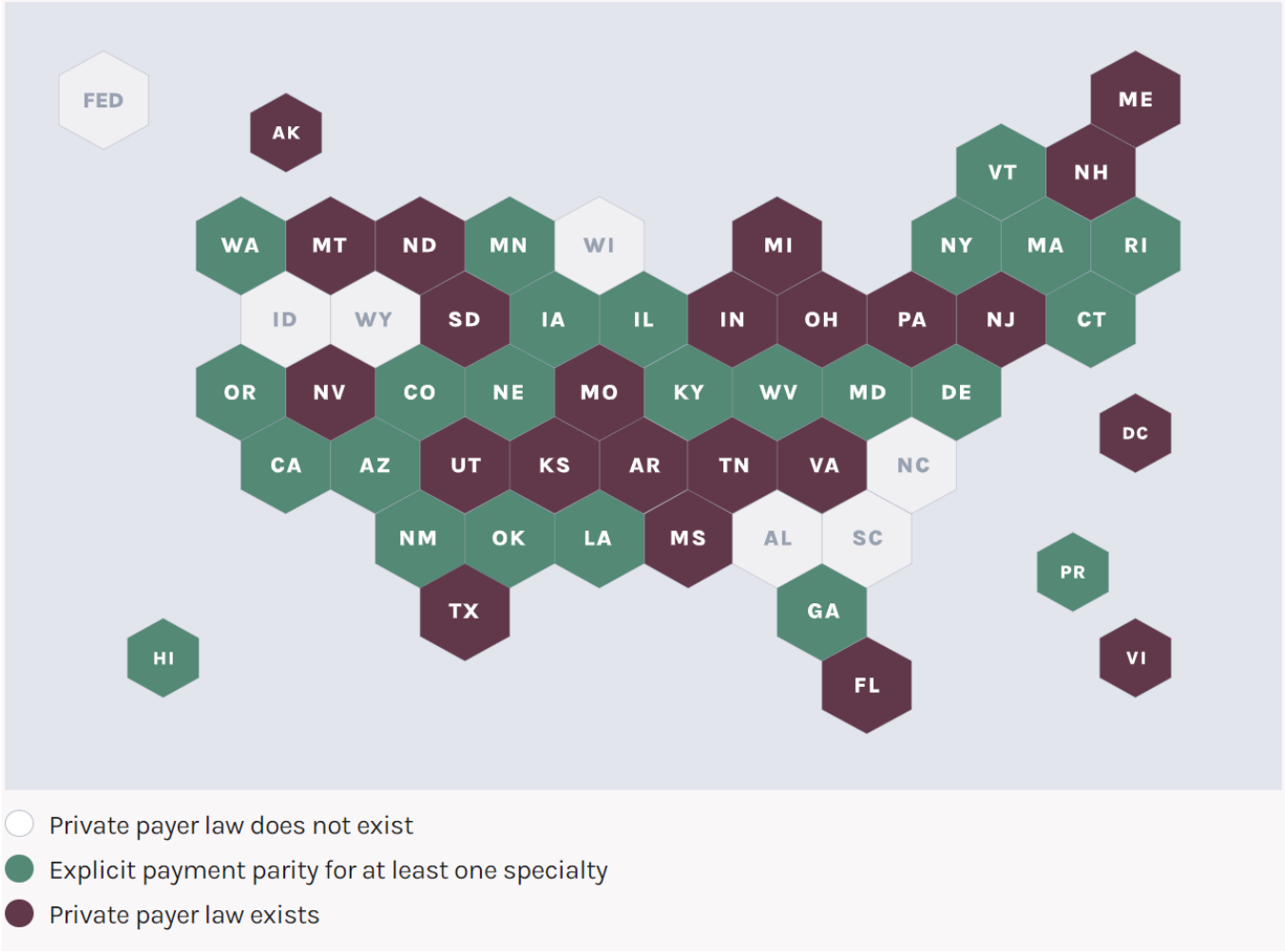
Key Takeaways – CY 2025 PFS Continued

- **Teaching Physicians:** Extend teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the service is furnished virtually through December 31, 2025

- **RHCs and FQHCs:**
  - Proposing to continue allowing direct supervision via interactive audio and video telecommunications and to extend the definition of "immediate availability" to include real-time audio and visual interactive telecommunications (excluding audio-only) through December 31, 2025.
  - Proposing to allow payment, temporarily, for non-behavioral health visits furnished via telecommunication technology. Under the proposal, RHCs and FQHCs would continue to bill for RHC and FQHC services furnished using telecommunication technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2025.
  - Proposing to continue to delay the in-person visit requirement for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026.
  - No proposed changes for payment parity for FQHCs furnishing medical services via telehealth.

Billing & Coding

Telehealth Parity



Maine
- MaineCare: Service & Payment Parity
- Private Payers: Service Parity

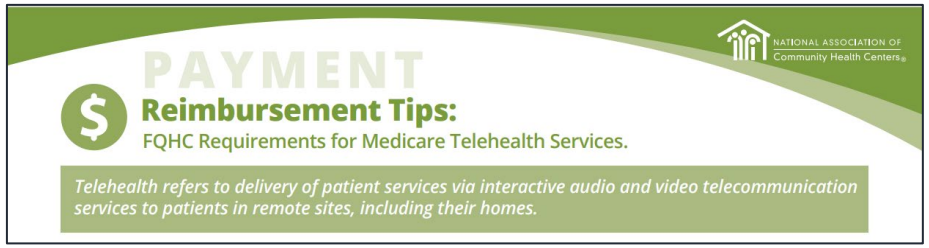
New Hampshire
- Medicaid: Service & Payment Parity, w/nuances
- Private Payers: Service Parity

Vermont
- Medicaid: Service & Payment Parity, w/nuances
- Private Payers: Service & Payment Parity (does not apply to value-based contracts)

Massachusetts
- MassHealth: Service and Payment Parity
- Private Payers: Service Parity & Payment Parity for BH Providers

[CCHP Policy Trend Maps]

Roadmap to Reimbursement



Key Considerations:

- **Documentation Requirements/Optimization:**
  - TH consent
  - Method of delivery
  - Patient and provider location
  - List any other participants
  - Total time spent
- **System Configurations:**
  - Template dropdowns, such as Audio only/Audio & Video
  - Macros in EHR for required documentation when TH is selected
  - Modifiers automatically inserted based on POS and payer
  - TH software that allows staff to mimic workflow of in-person care
  - Billing edits that include payer specific modifier and POS requirements

Telehealth Coding

2021 E/M Guidelines offer two paths for coding

Total Time

Medical Decision Making

New Patient Code	Time	Established Patient Code	Time
99201	N/A	99211	N/A
99202	15-29 min	99212	10-19 min
99203	30-44 min	99213	20-29 min
99204	45-59 min	99214	30-39 min
99205	60-74 min	99215	40-54 min

Telehealth Billing – Fee for Service

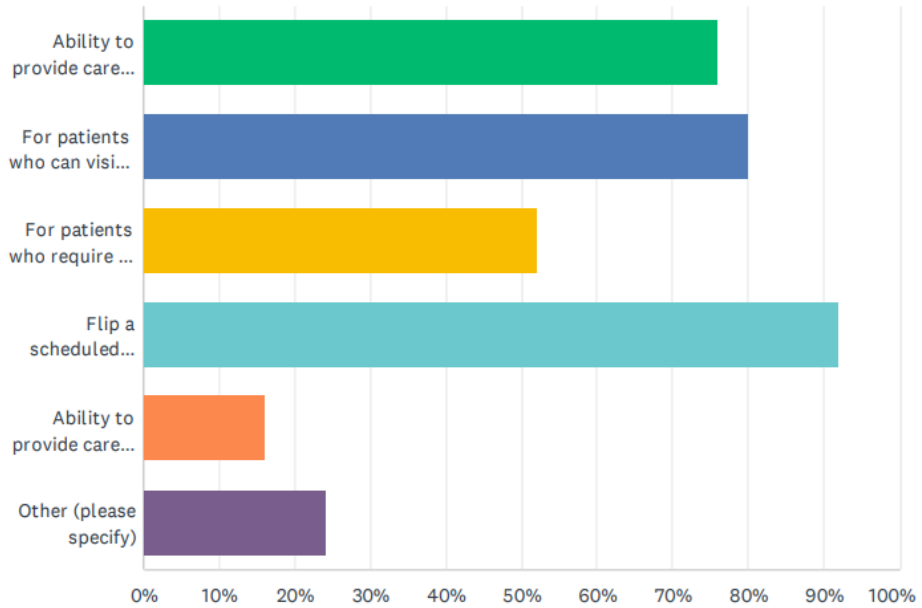
After correctly documenting and coding a telehealth visit, billing for telehealth services involves choosing the payer-specific place of service and code and appending the appropriate modifier.

Place of Service		Most Common Modifiers				
02-Patient Not home	10-Patient Home	93-Audio Only	95-Audio and Video	GT-Audio & Video (CAH) or common in State Medicaid Billing	G0-Acute Stroke	FQ-BH Audio only (FQHC & RHC)

Stay up to date on payer-specific guidelines to reduce unnecessary denials.

Q9 What do you see as the benefits of telehealth? (select all that apply)

Answered: 25 Skipped: 1



ANSWER CHOICES	RESPONSES	
Ability to provide care to patients who would normally visit the office if telehealth was not available	76.00%	19
For patients who can visit the office, offers another method for follow-up visits to reduce multiple in-person visits	80.00%	20
For patients who require a referral to a specialist but must be seen by the PCP first for insurance purposes	52.00%	13
Flip a scheduled in-person visit to telehealth because of extenuating circumstances	92.00%	23
Ability to provide care to patients who would normally require transfer to a tertiary care center/another hospital	16.00%	4
Other (please specify)	24.00%	6
Total Respondents: 25		

#	OTHER (PLEASE SPECIFY)	DATE
1	Patients with transportation issues	12/1/2023 7:36 AM
2	Ability to provide care for patients living far away/improve access to care	11/29/2023 9:52 PM
3	Still see the patient in some manner when we are low on rooming staff.	11/29/2023 9:52 PM
4	Great for pt with transportation issues	11/29/2023 5:30 PM
5	Patient preference, saves travel time, cost	11/29/2023 12:05 PM
6	Allows provider to see the family in their own home and provides insight into their family situation	11/1/2023 1:08 PM

Advantages of Telemedicine: General

Improve Access:	• Increases care when & where patients need it, • Improves capacity of providers • Reducing disparities
High Patient & Provider Satisfaction	• 95-100% satisfied with Telehealth compared to in person • 79% reported satisfied with care during their last telehealth visit
Cost Savings	• Value for patients, healthcare systems • Less ER visits, shortened hospital stays • Impact on environment
Patient Outcomes	• Physician shared: improved clinical outcomes (88%) care coordination (83%), increased patient adherence (81%), increased patient safety (82%) • Remote Monitoring: decrease in ER visits, reduced hospital stay length, patient engagement, provider access to patients

AMA, 2021; Bailey et a1,2021; Etz et al., 2023 Bell-Aldeghi et al., 2023; Aras et al, 2021; Butini et al,2023; Sharma et al, 2023

Understanding the Critical Advantages of Telehealth Adoption

1. **Patient Satisfaction**: 95-100% of patients satisfied with telehealth to in person visits; (Nguyen et al, 2020)
   - *Highlighting effective tool when providing care for obesity using the chronic care model
   - 79% were very satisfied with their care (Henry TA et al, 2021)
2. **Virtual Care provided key benefits to patients, noting**
   - Improved access , increased care when and where they need it
   - Cost savings
   - Reduction in health disparities
   - Roughly 88% of US want to continue having telehealth for nonurgent care post-COVID (Lagasse J et al, 2021)
3. **Provides cost reduction across sectors: patients, providers and payers (3 of the 6 P's)**
   - Nearly 70% of patients who would have gone to ED March – May 2023 if not able to use telemed visit option
   - Medicare Advantage study of claims data for acute & nonurgent care use found savings of 6% ($242 per care episode) by providing virtual care vs going to ED (noting a reduction in imaging, lab testing, antibiotics)
   - 20,000 uses of MD Live -17% lower costs vs non-virtual care, had a 36% net decrease in ED use per 1,000 people compared to non virtual users (National Committee for Quality Assurance)
   - Physician perspectives on quality: 88% shared telehealth improved clinical outcomes, 81% telehealth increased patient adherence, 82% increased patient safety, 83% that telehealth improved care coordination (AMA sept 2022)

https://www.americantelemed.org/resources/understanding-the-critical-advantages-of-telehealth-adoption/

Understanding the Critical Advantages of Telehealth Adoption

5. Impact on the Environment:

- ~5% of global greenhouse gas emissions related to healthcare industry within US healthcare accounts for 25%
- 5 Univ. California healthcare systems over 2 yrs: data noted telehealth eliminated 53,664,391 miles = 113 Trips from Earth to the Moon (Butini et al, 2023; Sharma et al, 2023)

6. Improving Patient Outcomes with Telehealth

- Chronic conditions and use of remote monitoring – area underutilized in pediatric obesity
- Remote monitoring has shown: decrease in ER visits, reduced hospital stay length, less travel while maintaining/improving care quality, increased patient engagement, increased provider access to patients (Hood et al, 2023)
- Psychotherapy adding to comprehensive behavioral health management (Totten et al, 2020)

  In ME - use of telemedicine adaptation of COPE for anxiety in children (ME AAP Grant)

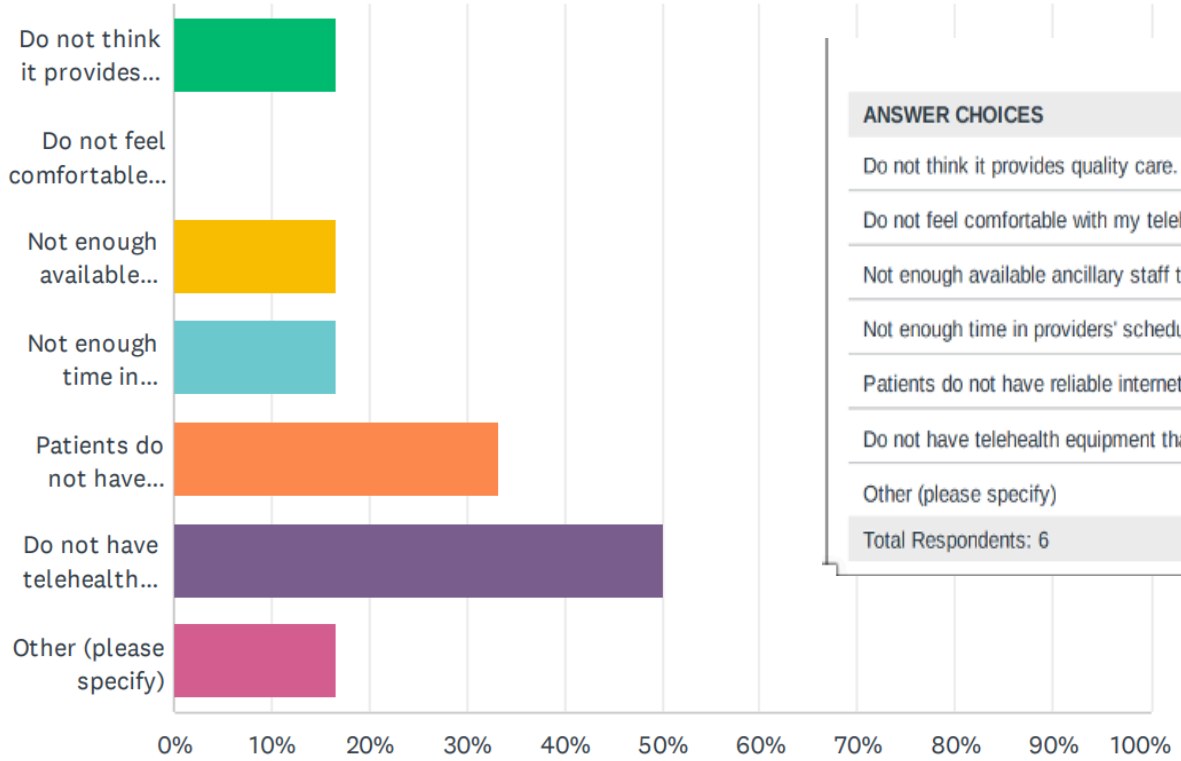
Recent Resources on Telehealth Quality/Impact

Updated MedPAC Report: June 2024

Bipartisan Policy Center Telehealth Brief: July 2024

Q3 If no, what are the reasons you are not using telehealth (select all that apply).

Answered: 6 Skipped: 20



ANSWER CHOICES	RESPONSES	
Do not think it provides quality care.	16.67%	1
Do not feel comfortable with my telehealth skills.	0.00%	0
Not enough available ancillary staff to set up the visits.	16.67%	1
Not enough time in providers' schedules.	16.67%	1
Patients do not have reliable internet access.	33.33%	2
Do not have telehealth equipment that is needed for visits (e.g., BP monitors, scales)	50.00%	3
Other (please specify)	16.67%	1
Total Respondents: 6		

Barriers of Telemedicine: General

Potential to worsen socioeconomic disparities particularly for vulnerable populations	• Need for Broadband to all • Technology devices availability equitably
Maintenance of Telehealth Policies to address Restrictions, Payment Parity	• Currently primarily limited to short-term financial measures to define Value • Prior Geographic & Provider specific limitations
Workflow Structure & Education of healthcare teams	• COVID highlighted need for stronger infrastructure, education, workflows and staff to support Telehealth • Ongoing payment uncertainty limited utilize/expansion of telemedicine

Barrier Drivers	• Competency Drivers:
	  • participant engagement barriers, staff training barriers, inadequate program supervision /management)
	• Organizational Drivers
	  • inadequate decision, administrative clinical supports, system-level & leadership barriers

(AMA 2021; Bailey et al, 2021; Etz et al. 2023)

Key references

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Tang M, Short L, June R, Dowling M, Mehrotra A. How to tap the full potential of telemedicine. 2023. Harvard Business Review. https://hbr.org/2023/06/how-to-tap-the-full-potential-of-telemedicine.

Crawford A, Serhal E. Digital health equity and COVID-19: The innovation curve cannot reinforce the social gradient of health. J Med Internet Res. 2020 Jun 2;22(6):e19361. doi: 10.2196/19361. PMID: 32452816; PMCID: PMC7268667.

Expanding telehealth in adolescent care: Moving beyond the COVID-19 pandemic.

Key points

- It is **essential to consider the full array of virtual care modalities to enhance access to care** for adolescents.
- A 2016 survey identified that only 15% of pediatricians had used telehealth in the previous 12 months, and the equipment costs and limited reimbursement were the most significant barriers to use.6 **Between 2008 and 2017, the use of telehealth in school-based health centers increased by 271%, with most of the growth occurring in rural schools and sponsored by hospitals**.
- A 2019 study of the use of in-home telehealth devices that included a stethoscope in children and adolescents with medical complexity revealed a lower rate of ICU admission in the intervention group, resulting in a cost savings of $9425 per patient over the course of the 4-month study with high levels of caregiver and medical team satisfaction.
- **Despite emerging evidence of the benefits of telehealth** for adolescents before the pandemic, **concerns regarding the lack of evidence supporting its use** and questions regarding the scope of health issues that were appropriate for care via telehealth **persisted.**
- The American Academy of Pediatrics Section on Telehealth Care Supporting Pediatric Research in Outcomes and Utilization of Telehealth has consolidated multiple national evaluation frameworks into 4 domains: (1) health outcomes, (2) health delivery: quality and cost, (3) experience, and (4) program implementation and key performance indicators.
- **Risk**: the chance to exacerbate health care inequities. ensure that telehealth products are developed with a focus on maintaining adolescent confidentiality.
- **Benefits:** Telehealth may allow an ongoing, adaptive conversation focused on adolescent wellness. can also be used outside of the direct clinician-patient relationship. Geography and capacity limits have reduced access to subspecialty care for adolescents, including with the Adolescent Medicine subspecialist- Virtual visits have tremendous potential to decrease geographic barriers.
- Telehealth has the potential to transform how adolescents engage with the health care system; however, **it is the responsibility of clinicians to adapt practice styles to meet the needs of adolescents and adhere to the expected standards for high-quality, confidential, and comprehensive models of care.**

North S. Expanding telehealth in adolescent care: Moving beyond the COVID-19 pandemic. Pediatrics. 2023 Apr 1;151(Suppl 1):e2022057267J. doi: 10.1542/peds.2022-057267J. PMID: 37010401)

What are future challenges of telemedicine?

Equitable access to Broadband & Technology Tools

- Variables:
  - demographics/geographical/cultural settings; medical models
- The Federal Communications Commission (FCC) 2018 Findings,
  - > 35% of U.S. rural households without broadband,
  - ~30 million Americans had limited access,
  - 60% of tribal communities had broadband access
- Worsening of disparities require policy & funding support

Need to Re-assess dated Telehealth Policies & Coverage of Services

- Risk of undue barriers to care
- Policy allows payer to influence when and how of telemedicine
- Clinicians can be trusted to determine when telemedicine is appropriate (shared decision making)

Defining Benefits & Value of Telehealth

- Expanding measures to define/assess value – re-envisioning the ROI
- Policies to consider models of reimbursement
- "Support for Frontline innovation is more likely to be successful than command and control top-down solutions"

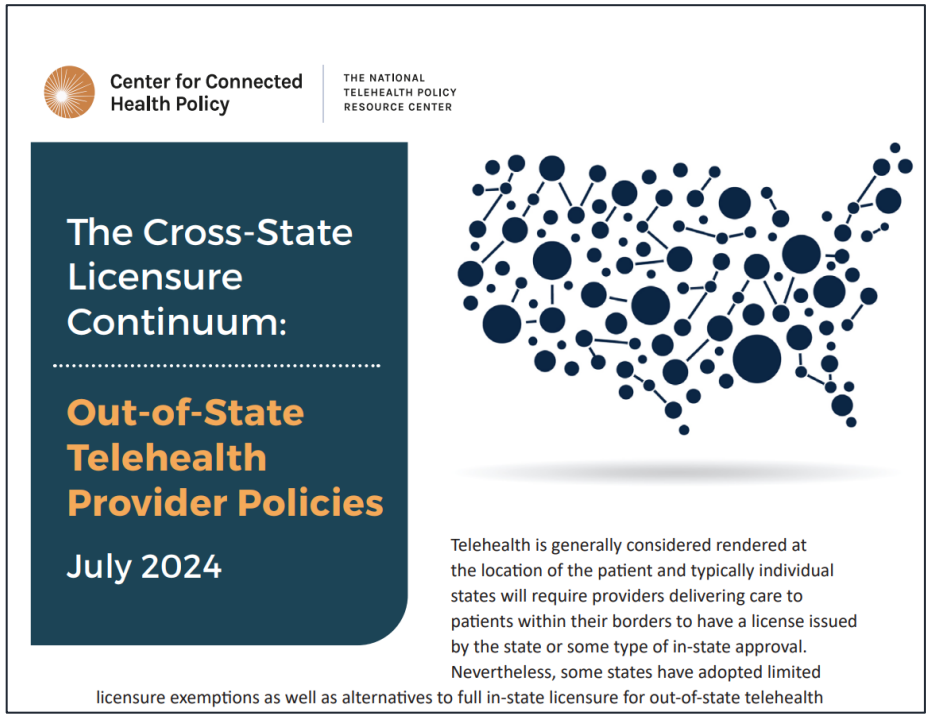
(Bailey et al., 2021; Etz et al. 2023; FCC 2023; Crawford et al., 2020; North, 2023; O'Hara et al. 2023; Woo Baidal et al., 2019)

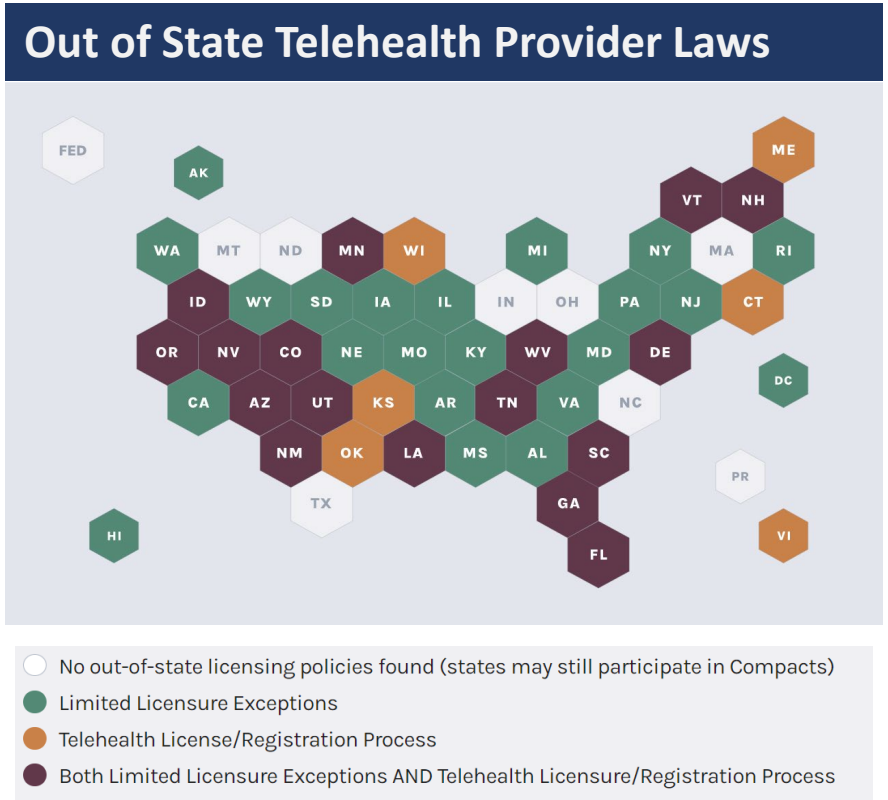
Cross-State Licensure and Telehealth

LATEST LICENSURE NUMBERS

(as of 7/18/24)

- **36** Jurisdictions have limited licensure exceptions
- **20** Jurisdictions have telehealth registration processes
- **14** States have both limited exceptions and a telehealth registration process
- **11** States don't have specific exceptions/registration (9 are members of compacts)
- **5** Jurisdictions are members of no compacts
- **2** States have no exceptions/ registration/compact





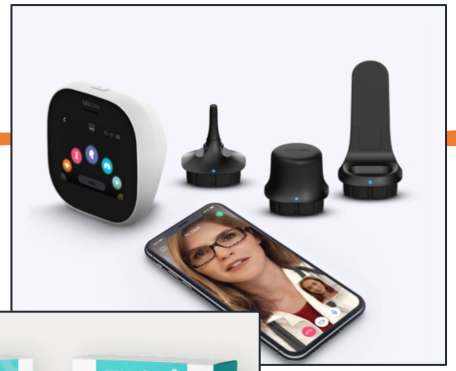
[CCHP Policy Trend Maps]

Telehealth Technology & Funding

TTAC
TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Alaska Native Tribal Health Consortium (ANTHC)
National Telehealth Technology Assessment Center (TTAC)

Crystal Ball Project:
What Technology will most impact Healthcare in the next 3-5 years



Coverage of TH at Home:

- Insurance Plan Covers Telehealth?
- FDA Clearance of Device?
- FSA Can Pay for Device?

Mid-Atlantic Telehealth Resource Center

TELEHEALTH
PLATFORM
SELECTION

Cost of a TytoCare visit

If your insurance covers telehealth visits, then it will cover a TytoCare visit. The copay should be the same for a visit with and without a TytoCare device. Due to COVID, almost all US insurance companies cover telemedicine and many are providing it for free. If it isn't free the co-pay is usually less than $59.

TytoCare visit	Urgent Care	Emergency Room
$59	$166	$570

No Service: Est. **0.7%** of locations

Unserved

Est. 6.3% of locations. M
have connection, but
unreliable. To addre
community-driven,
scale Public Private
Partnerships.

Deployments under
currently via ARPA f
**The % may be incre*

Most Critical / No Connection

Est. 5.6% of locations.
t and

Maine's Progress to Date:

- **Only 5% of locations in Maine remain unserved by modern internet.**
- **Over 86,000 connections have been directly funded since 2020.**
- **Over $250M of investments have been made since 2020, braiding state and federal funds.**
- **Approximately 1.5% of locations (~9,000) in Maine have no internet service option available. Working Internet ASAP will provide a connection through low earth orbit (LEO) satellite, which will be available by the end of 2024.**

Check out Maine's 5-Year Digital Equity Plan!

State of Maine
Digital Equity Plan

MAINE CONNECTIVITY AUTHORITY

Ensuring Equity

How can we address health equity through telehealth?

How can we ensure equitable access to care?

- Staff training and awareness
- Access to affordable broadband and technology
- Support for patient access and digital literacy
- Equitable program design (e.g. interpreter services, adaptive devices and software)
- Data
- Other?
  - Crawford A, Serhal E. Digital health equity and COVID-19: The innovation curve cannot reinforce the social gradient of health. J Med Internet Res. 2020 Jun 2;22(6):e19361. doi: 10.2196/19361. PMID: 32452816; PMCID: PMC7268667.

Ensuring Quality

What's included?

- Etiquette and Professionalism
- Appropriate applications for when telehealth should and should not be used
- Access to medical records
- Proficiency in taking history and performing appropriate physical exams
- Adequate technology quality (audio, video, etc.)
- Use Peripheral devices
- Privacy and Consent
- Accessibility
- Other?

Check it out – Telehealth Quality Course!

Telehealth Metrics Tracking

Service Performance	• Patient Satisfaction • Staff Satisfaction
Financial Impact	• Visits by Type/Volume • Reimbursement by Payer by Modality • No Show Rates • Patient Cost Savings
Technical Performance	• Connectivity • Wait times
Adoption/Engagement	• Care plan • Follow-up
Social Determinants of Health	• Limited Mobility • Transportation • Childcare

Resources on Telehealth Policy – after PHE

Table 1. Telehealth Policy Resources

Center for Connected Health Policy (CCHP)	https://www.cchpca.org/
	MEDICARE-TELEHEALTH-POLICIES-POST-PHE-AT-A-GLANCE-FINAL-MAR-2023.pdf (cchpca.org)
	CCHP Video Learning Series: Telehealth Policy 101, 201 & 301
	State Policy Finder Tool
	Billing For Telehealth Encounters
American Telemedicine Association (ATA)	https://www.americantelemed.org/policy/
Center for Telehealth and e-Law (CTeL)	https://ctel.org/policy-issues/
National Consortium of Telehealth Resource Centers	Preparing For The End Of The PHE – Provider Communication
	Preparing For The End Of The PHE And The End Of HIPAA Enforcement Discretion
Centers for Medicare and Medicaid Services (CMS)	Coronavirus Waivers and Flexibilities: https://www.cms.gov/coronavirus-waivers
	COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers (cms.gov) – last updated 10/13/22
Federation of State Medical Boards	U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19 (Out-of-state physicians; preexisting provider-patient relationships; audio-only requirements; etc.) – last updated 4/12/23
Telehealth.hhs.gov	https://telehealth.hhs.gov/providers/telehealth-policy

https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency

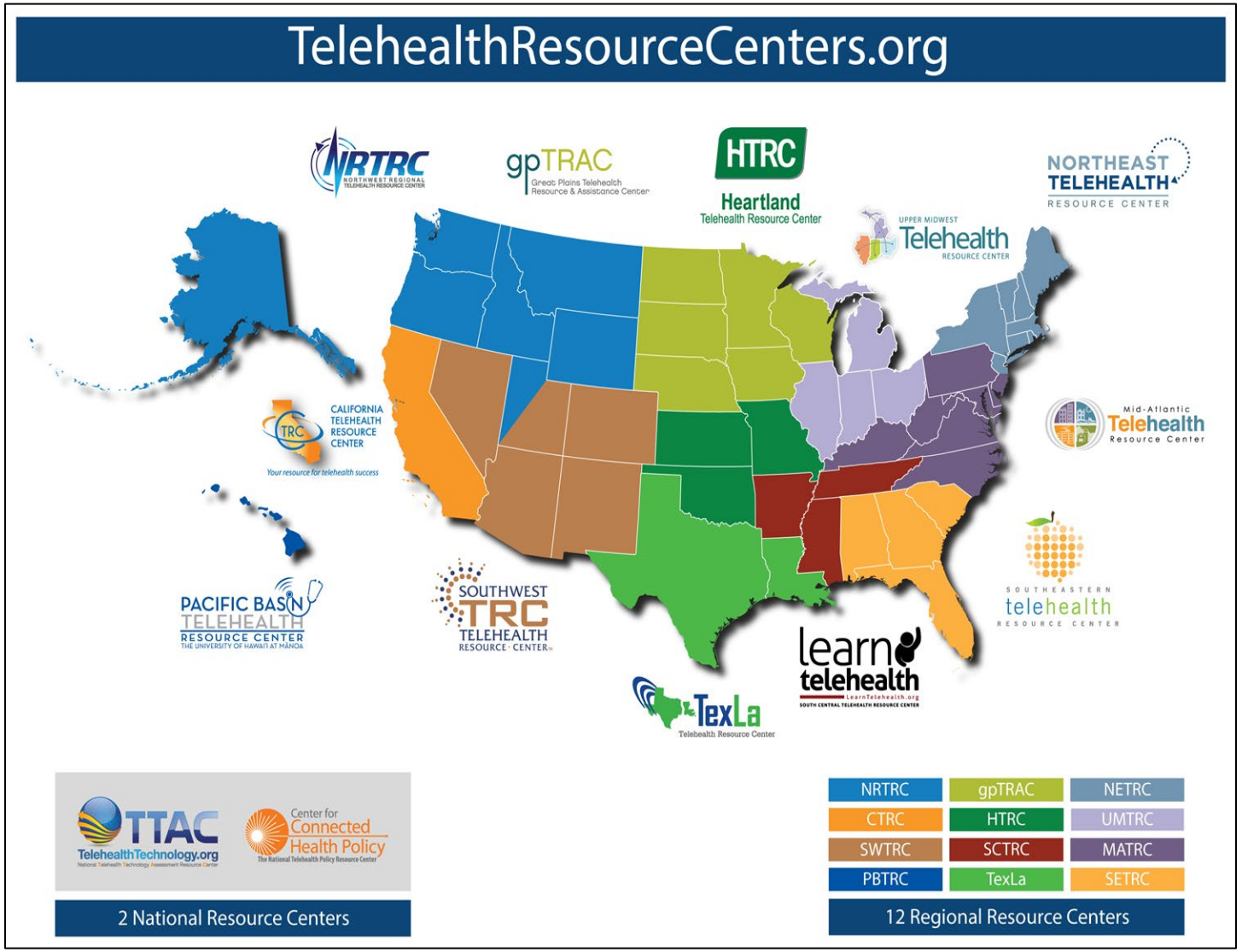
*Permanent/ Temporary Changes

Additional Resources

- FAQs: CMS waivers, flexibilities, and the end of Public Health Emergency (PDF) — Centers for Medicare and Medicaid Services (CMS)
- Telehealth Policy
- Telehealth Flexibilities and Resources and the COVID-19 Public Health Emergency — Department of Health & Human Services
- Coronavirus waivers & flexibilities — Centers for Medicare & Medicaid Services (CMS)
- Post-PHE Billing Policies FAQs — National Policy Center — Center for Connected Health Policy
- What Do I need to Know: CMS Waivers, Flexibilities, and the End of the COVID-19 Public Health Emergency (PDF) — Centers for Medicare and Medicaid Services (CMS)

O'Hara et al, 2023 Pediatric Obesity Care via Telemedicine: Expanding the Path Forward, a Review . **Current Obesity Reports**

Telehealth Resources



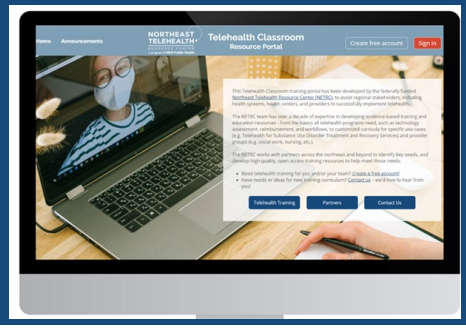
- **Northeast Telehealth Resource Center**
  www.netrc.org
- **National Telehealth Resource Centers**
  www.telehealthresourcecenters.org
- **Center for Connected Health Policy**
  www.cchpca.org
- **Telehealth Technology Assessment Center**
  www.telehealthtechnology.org
- **American Telemedicine Association**
  www.americantelemed.org
- **Center for Telehealth & e-Health Law**
  www.ctel.org
- *And many great regional programs willing to share!*

TRC Services – Meeting You Where You're At!

- Reimbursement
- Program development
- Strategic planning and market analysis
- Licensing & credentialing
- Malpractice & liability
- Regulations & other legal considerations
- Internet prescribing
- Technology selection
- Security, privacy, & HIPAA compliance
- Workforce development and training
- Best practices and networking
- Broadband Expansion and Digital Equity/Inclusion
- Telehealth Access Points (TAPS)
- Tools, sample forms, templates, etc.
- Program evaluation
- Research and Supporting Evidence

And More!!

TRC Training Resources



NCTRC Website and Webinar Series

Fact sheets, podcasts, training materials and more: www.telehealthresourcecenter.org

NCTRC hosts an educational webinar every 3rd Thursday of the month 2-3PM EST

Watch videos from previous webinars on our Youtube channel: www.youtube.com/c/nctrc

Check These Out as Well!

[CTRC Telehealth Course Finder]
[Southwest TRC Online Video Library]
[South Central TRC Learn Telehealth Site]
[NETRC Telehealth Resource Library]
[Telehealth.hhs.gov – Events Page]
[Intro to Telehealth Training/Workforce Development]

NORTHEAST TELEHEALTH RESOURCE CENTER

Telehealth Classroom

We break it down. We make it easy.

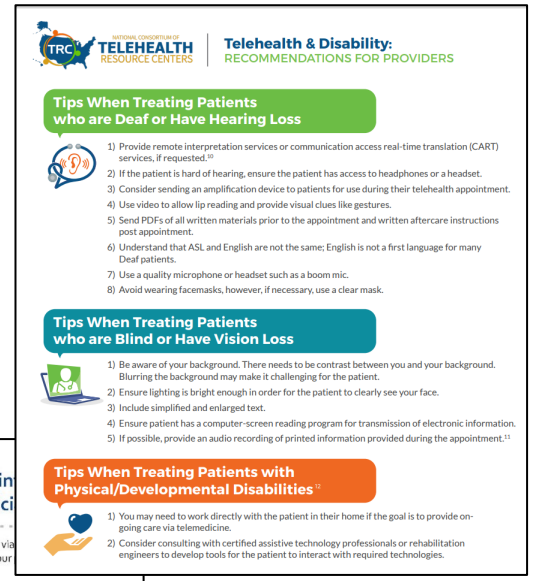
Check out our Current Courses > TelehealthClassroom.org

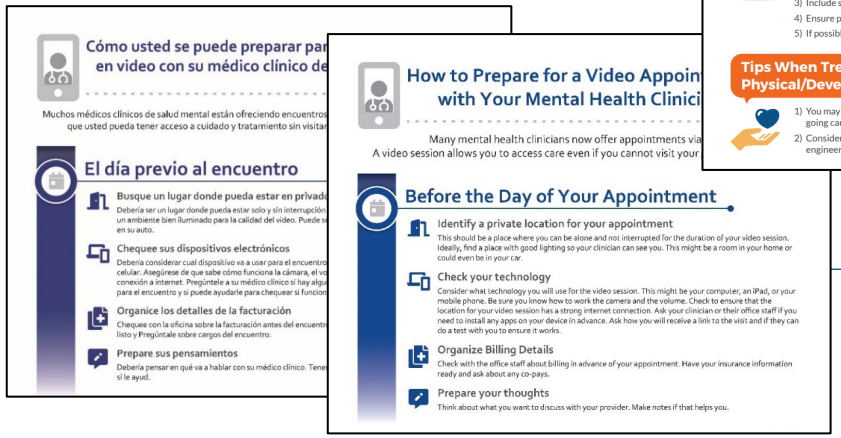
Find it on the [NETRC TH Classroom]!

- Achieving Quality in Telehealth
- TeleSUD TxRs Toolkit
- School-based Telebehavioral Health Toolkit
- Telehealth for Primary Care Toolkit
- Telehealth Basics for Community Health Workers
- eConsult Toolkit
- And More!

A Few Key Resources

- North Carolina DHHS Telehealth Guidance and Resources: Communication Access for Deaf, Hard of Hearing and DeafBlind Patients and their Providers
- National Consortium of TRCs - Telehealth and Disabilities: Recommendations for Providers
- WHO-ITU Global Standard for Accessibility of Telehealth Services
- APA/SAMHSA Tip Sheets - How to Prepare for Video Appointments with Your Mental Health Clinician: English and Spanish
- Evidence and Consensus-Based Digital Healthcare Equity Framework A PRACTICAL GUIDE FOR IMPLEMENTATION





Summary of Opportunities

Access

Address Health Equity by Building on Telemedicine Access Policies

Resource on available funding, successful examples

Ensuring Safety

Leveraging the patients Medical Home

Workflows to provide access to accurate medications for reconciliation, vital signs

Effectiveness

Telemedicine Policy & Broadband Funding

Need Access to provide effective medical care

Need to expand metrics to define effectiveness of care

Need expanded metrics that define Value of Telemedicine

Addressing Disparities

Maintain Permanent changes

Support at risk PHE Extensions

Expanding Broadband to all equitably (rural, SOE, indigenous populations)

Thank You!

Additional Resources

AMA Framework Resources

In addition, it is critical to highlight and support emerging innovations created by proximate leaders from marginalized communities focused on virtual care that centers equity for those communities.[viii] Below are selected initiatives, efforts and solutions that are advancing equitable virtual care:

INITIATIVE/SOLUTION	DESCRIPTION
Telemedicine for Health Equity Toolkit	A toolkit developed in partnership between the Center for Care Innovations, University of California - San Francisco Center for Vulnerable Populations and The Commonwealth Fund to provide background information as well as concrete guidance relevant to safety-net health care systems looking to initiate, expand or improve their telemedicine programs.
Health DesignED Center at Emory University	The Health DesignED team uses health expertise, design thinking and agile practices to prototype high-quality, equitable, tech-enabled acute care. They collaborate with innovators to support the evaluation of new products and practices by leveraging Emory Healthcare's pre-hospital footprint and five diverse EDs as a network of Test Beds. Once innovations have a record of improving quality and equity in patient care, they then support the rapid dissemination and scaling of the innovation to the populations that need them most.
Howard University College of Medicine 1867 Health Innovations Project	1867 Health Innovations Project is an innovation program that supports researchers, innovators, entrepreneurs and corporate partners who possess a desire to tackle complex health challenges confronting medically underserved communities.
HealthTech4Medicaid's Call for Telehealth Equity	HealthTech4Medicaid (HT4M) is on a mission to radically change the pace of innovation in Medicaid, improving quality and access to care for people who need it most. HT4M's Call for Telehealth Equity campaign focuses on enabling telehealth access to improve the lives of 1 million people in communities of color across the country.
Culture Care	Culture Care connects Black women with trusted physicians via virtual care.
FOLX Health	FOLX Health is a telehealth company designed by and offered to queer and trans people.

AMA Framework

FUTURE Opportunities:

Pediatric Obesity

V. Applying the Framework to New Digitally Enabled Care Programs

This section outlines how to apply the framework to new virtual care programs. The AMA recently published the Telehealth Implementation Playbook, Telehealth Quick Guide and Remote Patient Monitoring Implementation Playbook to aid practices considering adopting new virtual care programs. The Telehealth Implementation Playbook proposes 12 distinct steps that practices can take to support efficient, successful implementation of telehealth programs. The

FIGURE 13. STEPS IN AMA TELEHEALTH PLAYBOOK

Appendix

Presentation from
NETRC 2024 Regional Telehealth Conference

Maximizing Revenue for Telehealth Services

Christina R. Quinlan, Telehealth RCM Strategist

Northeast Telehealth Resource Center

Maximizing Revenue for Telehealth Services

Christina R. Quinlan, Telehealth RCM Strategist
Northeast Telehealth Resource Center

NORTHEAST TELEHEALTH RESOURCE CENTER NETRC.org

TELEHEALTH AWARENESS WEEK™

MCD Global Health

THE University of Vermont HEALTH NETWORK

THE University of Vermont MEDICAL CENTER

Eligibility Verification

NETRC 2024
A DECADE OF TELEHEALTH INNOVATION

Insurance Eligibility Verification is the process of determining a members insurance status, coverage, and liability.

More importantly, it's the process of confirming that a patient's insurance plan covers the services that will provided during the appointment.

By accurately verifying insurance eligibility, you can determine a patient's insurance status and coverage prior to the patient's appointment and give advance notice to the patient on what they are expected to pay.

Optimization of Documentation

Telehealth services should follow the documentation requirements as in-person care, with the following additions.

- Telehealth Consent
- Method of Delivery-Audio Only or Audio & Video
- Location of Patient
- Location of Provider
- List any other participants
- Total time spent

CMS-RHC/FQCH Billing for Mental Health Services via Telecommunications

Post PHE-FQHC's may continue to furnish mental health services via telecommunication for CPT codes listed under the PPS Mental Health Visit codes G0469 & G0470

Example Revenue Code	HCPCS Code	Modifiers
0900	G0470 (or other appropriate FQHC Specific Mental Health Visit Payment Code)	95 (audio-video) or FQ (audio-only)
0900	90834 (or other FQHC PPS Qualifying Mental Health Visit Payment Code)	N/A

FQHC Telehealth Originating Site Fee Q3014

FQHC Telehealth Originating Site	HCPCS Code
0780	Q3014: Telehealth Originating Site Fee

Note: Section 304 of the Consolidated Appropriations Act (CAA) of 2023 delayed the in-person visit requirements under Medicare for mental health visits that RHCs and FQHCs provide via telecommunications technology. For RHCs and FQHCs, in-person visits will not be required until after 01/01/2025.

RHC's bill with the same as above, with a CG modifier. G0469 or G0470 CG, 95 or FQ (93)

Delayed in-person visit through December 31, 2024. 2025 PFS would extend this to December 31, 2026

Telephonic E/M Codes

- CPT Codes 99441-99443 and G0071 for RHC/FQHCs Post PHE (Medicare) are for MD and DO
- CPT Codes 98966-98968 and G0071 for RHC/FQHCs Post PHE (Medicare) are for NPP (PA, NPs)
- These codes are for triage or virtual check-ins. They are intended to be brief medical discussions or clinical advice given to a patient by telephone, audio, and video.

Scenario:

- Patient calls to be seen.
- Patients transferred to the triage provider (including RNs during PHE)
- Brief Clinical Discussion and advice is given greater than 4 minutes.
- It is determined that the patient does not need to be seen within 24 hours
- Patient is okay with Plan
- Bill Telephone E/M

Documentation

- Verbal Consent is required
- Patient Initiated
- Documented in the medical record
- Not covered if the patient had an E/M visit within the last seven days or the next 24 hours

Billing & Coding for RPM

NETRC 2024
A DECADE OF TELEHEALTH INNOVATION

Remote Physiologic Monitoring

- 99453: Initial set-up & Education
- 99454:Transmission of Data
- 99457: Management services initial 20 min
- +99458 Management services-add'l 20 min
- 99091-Collecting and analyzing data

According to CMS rules, RPM services must meet the following criteria to qualify for reimbursement:

The RPM service must monitor an acute care or chronic condition.

The device used to collect and transmit data must meet the FDA definition of a medical device.

RPM data must be collected for at least 16 out of 30 days each month.

Data must be electronically collected and automatically uploaded to a secure location made available to the billing practitioner.

The RPM service may be provided by auxiliary personnel under general supervision of the billing practitioner.

RHC/FQHC: Beginning January 1, 2024, RPM codes will be reimbursed under the general care management code of G0511 at $72.98.

Billing & Coding for RTM

NETRC 2024
A DECADE OF TELEHEALTH INNOVATION

Remote Therapeutic Monitoring	
• 98975=Initial Set-up and Patient Education, requires 16 days of monitoring. One time per episode of care. • 98976-Supply of device for monitoring respiratory system • 98977-Supply of device for monitoring musculoskeletal system. Billed once per 30 days. Must have 16 days of monitoring • 98980- First 20 min of time spent reviewing, monitoring and analyzing data, program adjustments during the calendar month. • 98981-Each additional 20 min	Order from the physician or NPP
	Include RTM in plan of care
	Type of device used-name and description
	Specific education and training provided to the patient and/or caregiver
	Data gathered from the device automatically or patient reported
	The time spent should be reported per calendar month
	Date, time , and specifics of patient and/or caregiver interaction
	Decisions made that may impact treatment of care
	Only one provider can bill RTM/RPM per 30 days

RHC/FQHC: Beginning January 1, 2024, RTM codes will be reimbursed under the general care management code of G0511 at $72.98.

Billing & Coding for Online Digital E/M

Online Digital E/M

- 99421 (MD, DO) =5-10 Min
- 99422 (MD, DO) =11-20 Min
- 99423 (MD, DO) = 21+ Min
- 98970 (NPP) = 5-10 Min
- 98971 (NPP) = 11-20 Min
- 98972 (NPP) = 21+ Min

These codes are used when E/M services are performed through a HIPAA-compliant secure platform. Patient-initiated communications may be billed by clinicians who may independently bill an E/M service. They may not be used for work done by clinical staff or for clinicians who do not have E/M services in their scope of practice.

- Verbal consent is required by CMS.
- The service is documented in the medical record.
- The contact must be initiated by the patient using a digital platform, and the work time can be cumulative over seven days. The time includes:
  - The review of the patient's initial inquiry
  - The review of records or data pertinent to the inquiry
  - Any interaction with clinical staff focused on the problem and in the development of management plans—including generation of prescriptions and ordering of tests and o subsequent non-face-to-face communication with the patient that does not represent a separately supported E/M service
- If the patient had an E/M service within the last seven days, these codes may not be used for that problem.
- If the inquiry concerns a new problem (from the problem addressed at the E/M service in the past seven days), these codes may be billed.
- If, within seven days of the initiation of the online service, a face-to-face E/M service occurs, then the time of the online service or decision-making complexity may be used to select the E/M service, but this service may not be billed.
- This is for established patients, per CPT®.

Virtual Communication Services (VCS)

NETRC 2024
A DECADE OF TELEHEALTH INNOVATION

RHC/FQHC

Virtual Communication Services also known as CTBS: Communication Technology-based Service.

Communication Modalities Synchronous and/or asynchronous; through telephone, audio/visual, secure text messaging, email, or patient portal.

Qualified Providers: Health care professionals who can report evaluation and management services. Virtual Check-Ins have also been expanded for other practitioners, such as physical therapists, occupational therapists, speech-language pathologists, LCSWs, and clinical psychologists. (Includes RHC/FQHCs)

FQHC's and RHC's report G0071 for all VCS/CTBS Services.

VTC/CTBS are not considered Telehealth by CMS Definition

G2010 (remote evaluation services). Remote evaluation of recorded video and/or images submitted by the patient (i.e., store and forward), including interpretation and follow-up with the patient within 24 business hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment

G2012 (communication technology-based services). Brief communication technology-based service, i.e. virtual check-in by a MD/DO or other qualified healthcare professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous seven (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.

G2252 (communication technology-based services). Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services provided to an established patient, not originating from a related e/m service supplied within the previous seven days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion (not billable to Medicare)

Telehealth Reimbursement

NETRC 2024
A DECADE OF TELEHEALTH INNOVATION

Payment Parity requires that healthcare providers be reimbursed the same amount for telehealth visits as in-person visits.

Coverage parity is not the same as payment parity. Coverage parity means that if a service is covered for in-person care, it must be covered if furnished via telehealth, but payment parity means that it will be reimbursed at the same rate.

Determine the Type of Telehealth

- Telehealth/Telemedicine
- Telephone E/M
- E-Visits
- Virtual Communication Services/CTBS

Navigating Medicare

- Defining Originating and Distant Site (waived during PHE)
- The patient must be in a HPSA (Health Professional Shortage Area (waived during PHE)
- Only certain CPT and HCPCS codes are eligible for reimbursement (Billing Department should keep you updated)
- Use Proper Modifier (Billing Department should be communicating these changes and your EHR and PM should have edits in place)

Private Payers: (Billing Department)

- What CPT and HCPC codes can be delivered via telehealth?
- Are there any restrictions on the location of the patient or provider?
- What modifiers do we need?
- What is the correct place of service code (POS)?
- Which providers are eligible?

Navigating Medicaid

- Review state policy (many states have already made permanent changes)
  - Health Services Covered
  - Eligible Providers
  - Licensing (cross state)
  - New Patient allowed
  - Covered CPT codes
  - Type of Reimbursement (hospital/FFS/facility or both)

System Configuration