FLORIDA ACADEMY OF FAMILY PHYSICIANS

SUPPORTING FLORIDA'S FAMILY PHYSICIANS

Telemedicine 2.0 - Lessons Learned (Panel Discussion)
April 23, 2020
Question/Answer Submissions

Question 1: Does anyone have experience in utilizing telemed for specialists in the inpatient setting?

- No, but audio/ video inpatient telemedicine visits performed by hospitalists and specialists are being reimbursed during the pandemic.

Question 2: I did a virtual visit with a deaf patient today via texting. What CPT code would I use?

- Consider telephone CPT codes (99441-99443), or a Virtual Check-In visit if covered by their payer. The patient has to consent to having a Virtual Check-In visit. You typically cannot bill for a telemedicine visit with text/ audio only.

Question 3: What if a patient expresses suicidal ideation or plan on a telemedicine visit?

- Ideally before each telemedicine visit staff members or the physician should get an updated current contact number for the patient. As with in-person visits, consider Baker Acting the patient if they have a plan or intent of suicide, and potentially seem to be a risk to themselves or others. Local police can go to the patient's home to transport them safely to the receiving facility.

Question 4: Is there a plan for FAFP/AAFP to advocate for continued payment for telemedicine, once the emergency order is lifted?

- Yes, the FAFP is working with all public and private payers to ensure appropriate payment in what will undoubtedly be a healthcare delivery system more dependent upon virtual patient visits. Telemedicine must be recognized and reimbursed at a level that is commensurate with the clinical decision making and effort expended to provide quality care, not the way in which it is delivered.

Question 5: If history and physical is not required then I can easily forget asking a patient about cardiac health and rhythm problems. So, if he/she is being prescribed Hydroxychloroquine and develops intractable cardiac arrhythmia and subsequently dies guess who is being blamed for negligence.

- In the webinar it was mentioned that the number of H&P elements in the note is no longer one of the requirements for determining billing level – you should mainly use complexity of visit or the medical decision making (MDM) time. As with in-person visits, an appropriate history and virtual assessment/ physical should be performed to best determine the diagnosis and necessary treatment/ interventions.

Question 6: Most insurance companies push their members to demand telemedicine visits from their doctor because it's cheaper. How does this affect the quality of care?

- The entire world of telemedicine, including guidelines and payer reimbursement for these services, has completely changed. Primary care physicians need to be actively engaged with the creation of new telemedicine regulations and policies, to ensure that remote patient care is appropriately utilized and reimbursed. Proper use of telehealth has shown to improve patient health outcomes.

Question 7: Family physician for decades advocate patient parity including equal access to medical treatment. It's a fact that many of the working poor have NO cable and /or highspeed internet access which is required to perform bidirectional video communication. Many do not even have access to a laptop or PC except in the public library. Therefore, Telemedicine can further aggravate the digital divide between rich and poor. What is your opinion?

- Some practices are applying for grants or other funding to try to overcome the "digital divide", or they are finding other ways to care for patients faced with these disparities. Some health care systems have created mobile telehealth buses or units, or telemedicine "kiosks" at local stores and community centers. Funds from the CARES Act can assist with providing needed equipment or broadband access. It is important to ensure that ALL of our patients have appropriate access to adequate healthcare, and we should of course ensure that telehealth in primary care aligns with this philosophy.

Question 8: To start a Telemedicine, practice a physician needs to invest in the hardware and subscribe to a software package which can easily cost $200/month. Insurance companies advertise their telemedicine services as free (no copays) which means that physicians take a financial risk. It appears that physicians cannot avoid embracing telemedicine services but can they afford it?

- As discussed during the webinar most patients like having a telemedicine option, and not having telemedicine as part of your practice could be a deterrent for patients selecting their physician in the future. I hope that payers will reimburse at a rate that will allow for provision of telehealth services in the future, but this will require advocacy and leadership on our part.

Question 9: What do we know about legal liability and medical malpractice related to the use of Telemedicine?

- Prior telemedicine malpractice research before the pandemic did not reveal any significant liability issues. Physicians who comply with licensing rules, who document appropriately, and who follow the same standards of care they would for in-person treatments do not create additional malpractice risks just because they're offering their services virtually. However, we are doing A LOT more telemedicine visits now, and we should responsibly utilize telemedicine and appropriately document reasons for our clinical decisions, patient consent, and privacy risks.

Question 10: Can you ask Dr Jenkins if the CR modifier she referred to the same or different what Medical Economics calls the CS modifier?

- The presentation slide should have said "CS" for the cost-waiving modifier, and not "CR". Although the CR modifier was initially being used for claims related to COVID, CMS has now asked that the CS modifier be used as of mid-March.