March 31 Telehealth Session Chat Comments

Participants were allowed to submit questions in advance and reply to speakers throughout the informational session.

Bill Galvin asked: Will info/slides be made available after?

Lee H. Schwamm, MD wrote: reference for ATA definitions. Telehealth includes a growing variety of applications and services using two-way video, email, smart phones, wireless tools and other forms of telecommunications technology. Telehealth is not a separate medical specialty. It is a delivery tool or system. Closely associated with telehealth is the term "telemedicine," which may be used interchangeably with telehealth, but is sometimes used to encompass a broader definition of health care that uses telecommunications technologies. Videoconferencing, transmission of still images and other data, e-health including patient portals, m-health, remote monitoring, continuing medical education, and medical call centers, are all considered part of telemedicine and telehealth" (ATA, 2007).

Bob Ward wrote: On this section. I agree with MMS comments but the cost of the technology platforms should be considered. Telephone, vs Video; vs complex monitoring devices… That may drive the differential But totally agree that the cognition necessary to treat the patient should always be considered.

Chris Garofalo,MD wrote: I would expand on Dr. Spivak's comments to add that much of our office infrastructure is involved in these visits, ie my scheduler or receptionist will take the phone call from the patient and schedule the appointment, my medical assistant will set up the visit in the EMR and will be responsible for scheduling any follow up referrals, testing, etc. TH visits involve nearly the same amount of "work" as an in-office visit and should be reimbursed at parity.

Bissan Biary shared a link: https://www.cms.gov/files/zip/list-telehealth-services-calendar-year-2021.zip

Steven Locke, MD wrote: Reimbursement models that make a non-parity distinction between real-time audio only would increase disparities in care and be discriminatory in the case of patients who only have telephone access or cannot use more advanced communications devices including smartphones, tablets, laptops, etc or who do not have broadband access.

Janice Karin added: and disability access

Steven Locke, MD wrote: Yes, thanks

Hilary Jacobs wrote: It's imperative to continue telephonic interactions to address significant health disparities that exist in terms of access to devices due to poverty, homeless individuals, elders, etc. I agree with Dr. Spivak the issue should be complexity, not device used.

Barbara Spivak wrote: I strongly agree with Dr. Locke. Particularly the elderly and the disabled do not have access to visual technology.

Richard Follett wrote: The rate of reimbursement for audio only cpt codes does not cover the costs associated with the true components of the E&M services, delivery. It is important to understand that audio only is essential for several patients who do not have access to computers technology and or are

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not comfortable with that technology. This creates a disparity and a burden on the level of service provided to those individuals.

Philip Ciampa wrote: Agree with comments here from Dr. Locke, Dr. Schwamm. Complexity of the care and not modality should be driving reimbursement. A differential payment for telephone visits vs. video visits will drive disparities.

AnnMarie ONeill wrote: I agree with reimbursement should be in line with complexity. This is in line with the new 2021 E/M Guidelines - a focus on MDM. Depending on the issue, the physician may have a significant amount of work to do following a call to adequately treat the patient.

Hilary Jacobs wrote: We need to consider that telehealth also covers behavioral health visits, not just primary care and medical specialty care visits, which has been the focus of most of the comments today.

Melinda Edge wrote: At preset, CMS is limited by the ACT in making audio-only telephone visits permanent. There is a bill before Congress to amend Title XVIII of the SSA to expand accessibility to certain telehealth services under the Medicare Program. The bill is called "Permanency for Audio-Only Telehealth Act"

Steven Locke, MD wrote: If audio-only is reimbursed at a lower rate, it could lead to pressure on the patient to come to the office when remote care would be preferable, not only for convenience, but for safety reasons. An obvious example is when the community is in the midst of a pandemic or epidemic.

Judith Melin wrote: Terminology considerations/complexities: Telehealth visits occur in-person, as do office visits.

Melinda Edge shared a link to the bill:
https://connectwithcare.org/wp-content/uploads/2020/12/Permanency-for-Audio-Only-Telehealth-Bill-Text.pdf

Bob Ward wrote: perhaps a modifier or add on code to reflect the type of modality. The base code would be at parity

Lee H. Schwamm, MD wrote: the existing codes for in person that are currently recognized

MD & APP (Aligned with Medicare)
99211-99215- Established Patient E&M
99202-99205- New Patient E&M
99241-99245 – Consultation Codes between MD and patient (when allowed -some payers still pay them some don't)
90832-90853 – Behavioral Health Therapy codes
90791-90792- Psychiatric assessment codes for new patients

Donna Campbell wrote: I agree with the modifier suggestion, but consistency across all payers is key.

Janice Karin wrote: there still could be patient safety issues requiring telehealth that are not pandemic-related

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Philip Ciampa wrote: Agree with Janice—thinking of my elder patients, flu season, etc.

Steven Locke, MD wrote: Sitting in a waiting room is not without its own risks from infectious diseases — with or without a pandemic. Furthermore, having a financial issue being the determinant of whether an office visit is needed is not good public health and fraught with problems related to health care disparities.

Janice Karin noted: and also on the subject of inequities, onsite visits can have significant time commitments from patients who require public transportation, and policies that turn away patients who are more than 10-15 minutes late exacerbate this as they need to take even more time off to leave earlier - and still may miss the appointment so they need to take time off twice

Chris Garofalo, MD: Agree with Dr. Locke, having a disparity in payment ie paying TH visits at higher or lower rates risks incentivizing visits in 1 direction or the other ie we don't want to pay much more for a TH visit as this may incentivize doing a TH visit when an in office visit is more appropriate.

Janice Karin added: or take time away from other things if it's not a time off work thing)

KPars asked: Do the differences between A/V and audio-only billing include whether facility fees can be charged? (I was a bit late - apologies if this was already covered)

Kathy Keough wrote: Agree with Michael on Global payments

Heather Meyers - Boston Children's wrote: Also agree with Michael and Liz on global payment

Steven Locke, MD wrote: The specialty that will account for the largest proportion of telehealth delivered care is behavioral health. One concern, not limited to telehealth, with regard to global payments is the risk that some HCOs may underfund BH services because of lack of political power in the decision-making processes that lead to determination of how the global payments will be allocated to different clinical services.

Kathy Keough wrote: Pediatricians are also dealing with a huge uptick of their patients requiring BH services

Steven Locke, MD wrote: I agree with Dr. Spivak

Karen Granoff wrote: agree with Dr. Spivak regarding expanding primary care to include BH services delivered by Primary care clinicians. Dr. Kimball is correct - OON telehealth should be handled NO differently than any other out of network services are handled. If the network is inadequate or there are medical necessity reasons, then the services should be covered in the same manner as in office visits would be handled.

Bob Ward wrote: It appears that the statute is clear that it refers to BH Services - not the discipline or specialist providing the service.

Philip Ciampa added: Agree with Dr. Spivak, and Karen Granoff’s comments

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Steven Locke, MD wrote: With regard to the in-network vs. out-of-network access to care, the DOI should monitor the difficulty that insureds have in accessing care, especially psychiatric care, when having to depend on closed networks. I agree with Dr. Chinman that restricting access to only in-network providers is creating significant access problems for patients.

Hilary Jacobs wrote: As I understand it, MassHealth redesign is considering an expanded vendor network to include solo and group practices to address issues of access and to allow patients to follow their providers as they move. I agree the access issues are significant as is the patient choice issue, and these benefits should be available out of network.

Philip Ciampa : Strongly agree with Dr. Schwamm's point here on management of chronic disease

Lee H. Schwamm, MD wrote: agree no need for additional CPT codes, just payment parity for the existing in-person codes when performed over AV or audio-only

Ellen Brennan wrote: Yes, 9700 series CPT codes for PT/OT would be appreciated for consideration

Heather Meyers - Boston Children's noted: Need consistency across payers when using telehealth modifiers across different types of technology. CMS recognizes both the GT (services provided via synchronous telecommunication) and GQ (an asynchronous telecommunications system)

Adam Delmolino, MHA: Thank you very much Kevin and all DOI staff. We really appreciate this opportunity for input.

Jatin Dave: Thanks everyone for your participation