



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.

Use of Telemedicine for Sexual Medicine Patients

Anjali B. Dooley, JD,¹ Nadia de la Houssaye, JD,² and Neil Baum, MD³

ABSTRACT

Introduction: Telemedicine (TM) will play a significant role in contemporary practices that diagnose and treat sexual medicine patients. Although only a small percentage of urologists, sex therapists, social workers, psychiatrists, gynecologists, and urogynecologists currently use TM, many more practices are going to embrace this technology in the near future. This article will discuss the process for implementing TM in sexual medicine with minimal time, energy, effort, and expense. We will also examine compliance and legal issues associated with implementing TM in practice and how to code for TM services based on regulatory guidelines.

Objectives: The purpose of this article is to improve the understanding of the concept and the trends of using TM to provide care for sexual medicine patients.

Methods: The study involves a literature review focussing on the new Centers for Medicare and Medicaid Services guidelines including the relaxation of the Health Insurance Portability and Accountability Act requirements.

Results: COVID-19 has changed the doctor-patient relationship especially in the area of sexual medicine. There are many patients with sexual medicine conditions that are amenable to the use of TM methods.

Conclusion: Virtual visit utilizing audiovisual telecommunications is a very attractive approach for sexual medicine patients. Many patients with sexual medicine problems are no longer going to accept the antiquated method of healthcare involving making an appointment, visiting a brick-and-mortar facility, and the requirement of having a physical examination. The new normal will be communicating with patients by utilizing TM.

Dooley AB, Houssaye N de la, Baum N. Use of Telemedicine for Sexual Medicine Patients. Sex Med Rev 2020;8:507–517.

Copyright © 2020, International Society for Sexual Medicine. Published by Elsevier Inc. All rights reserved.

Key Words: Telemedicine; Virtual visits; Guidelines for telemedicine; Telehealth

OBJECTIVES

Telemedicine (TM) is a new approach to treating sexual medicine patients. The purpose of this article is to share the advantages of TM and how to implement such a program in any practice managing patients with sexual problems and conditions. We also want to use this article to educate sexual medicine practitioners on the legal guidelines for using TM. Finally, no article on TM would be complete without a discussion on the importance of documentation and coding for a virtual visit. As Wayne Gretzky, one of the greatest hockey players, advised “A good hockey player plays where the puck is. A great hockey player plays where the puck is going to be.” And in this COVID-

19 era, the proverbial puck is going to be communicating with patients using TM.

RESULTS

Whether they know it or not, healthcare professionals caring for sexual medicine patients have for long practiced a form of TM—only without the video component. By taking phone calls from patients asking for medication refills or responding to patients after hours and on evenings and weekends, professionals have already availed themselves of a form of TM.

In the face of such patient demands, sexual medicine professionals either acquiesce and call pharmacies to refill the medications, or they deny requests and suggest that patients make an appointment and receive a new prescription. While the latter action will probably not endear patients to a sexual medicine provider, providers who acquiesce to patients’ phone requests to have prescriptions filled or otherwise seek free medical advice should keep in mind that they are not being compensated for providing these services. Not only are physicians legally responsible for their actions, by rewarding patients with a

Received April 11, 2020. Accepted June 7, 2020.

¹Law Office of Anjali B. Dooley, LLC, Saint Louis, MO, USA;

²Chair of the Telemedicine Healthcare Industry Group at Jones Walker, LLP, New Orleans, LA, USA;

³Tulane Medical School, Department of Urology, New Orleans, LA, USA

Copyright © 2020, International Society for Sexual Medicine. Published by Elsevier Inc. All rights reserved.

<https://doi.org/10.1016/j.sxmr.2020.06.001>

prescription or advice, but may also be inadvertently motivating them to continue to seek free medical guidance without making follow-up appointments.

As the legal landscape and regulations for reimbursement are changing to adopt TM more readily—particularly during the coronavirus (COVID-19) pandemic—TM is increasingly being used to handle rising demands on healthcare professionals and to reduce the spread of the disease. There is potential for TM to improve efficiency, reduce healthcare costs, and improve patient satisfaction. It is important to consult with a healthcare attorney who understands the technology, state-by-state regulatory challenges, and reimbursement challenges. Whether such advice comes from a competent legal counsel or a TM implementation company with its own in-house legal professional, the message is clear: guidance in this rapidly changing arena is imperative. Failure to do so—and the potential consequences of such inaction—do not make for good medicine.

On the upside, improvements in technology have changed the landscape of the entire healthcare industry and modern TM *can* be an important adjunct to a high-functioning sexual medicine practice. Among other benefits, sexual health professionals can be compensated for their text, phone, or video interactions with patients while practicing good medicine. TM can provide an electronic record of phone interactions and a seamless method of billing the patient or the insurance company for the virtual visit.

As providers for patients with sexual health problems, we are now able to leverage the advances in digital technology using TM while directly addressing some of TM's risks. The proper use of TM can lower the cost of healthcare for patients and providers. Professionals who harness TM will magnify their competitive advantage exponentially as they are now able to connect with their existing sexual medicine patients and attract new patients. Using TM, professionals will be able to reach patients in a larger geographic radius, rather than depending exclusively on time-honored word-of-mouth marketing to promote their practices. It is increasingly imperative that we embrace technologies that will make our practices more attractive to our patients.

Initially, TM's best use was for rural areas, where there were few physicians, especially urologists or sexual medicine professionals, and reimbursement was available for all specialists. As recently as 2018, an American Urological Association census showed that 62.3% of counties in the United States have no urologists.¹ The same report also noted that from 2011 to 2016, telehealth service use increased substantially, especially in rural areas (960%) of the country as compared to the somewhat slower (629%) growth in urban areas.

Now there is a trend toward more urban medical practices embracing TM. Currently, urban usage of TM has grown to match and even surpass rural usage. Between 2015 and 2016,

urban areas saw a jump from 25% to more than 45% use, while rural growth increased from 35% in 2015 to 40% in 2016.²

Kaiser Permanente Chief Executive Officer Bernard Tyson indicated that 52% of the more than 100 million annual encounters with Kaiser doctors took place remotely using TM.³ American Well (Amwell), a for-profit organization that has set the standard for online care, estimated that by 2022, between 341,000 and 591,000 U.S. physicians would be using telehealth to see patients.⁴

BENEFITS OF TM FOR PROVIDERS

Nearly all healthcare providers including non-physicians now recognize the demand for and the importance of using TM to care for patients. The number of physicians and non-urologists using TM continues to increase by about 20% per year and is likely to grow at an even faster rate in the near term. That coincides with the growth in TM patient visits, which increased annually by 261% between 2015 and 2017.⁵

The healthcare profession's primary mission is to diagnose and treat diseases and to do no harm. TM can solve several healthcare challenges: improved outcomes, reduced cost of care, and increased patient satisfaction. In other words, TM helps achieve a triple aim.⁶ Conducting a TM doesn't require any additional staff to accomplish the session, thus reducing the cost of care. Also, patients don't have to be moved from the reception area to the examination room and then to the checkout counter, thus improving the efficiency of the practice and allowing the providers to see more patients.

In particular, TM can increase efficiency and reduce expenses of caring for sexual medicine patients. It is possible for sexual medicine physicians to implement a TM program by starting with a smartphone or a tablet device with no requirement to purchase additional hardware or software.

TM enhances traditional face-to-face interactions between the patient and the sexual medicine professional. A strong doctor-patient relationship is the foundation of a model that has worked since the time of Hippocrates and which almost always begins with a face-to-face encounter between a patient and a healthcare provider. As such, TM should support, not replace, traditional care delivery. With TM care, providers can continue to provide care for patients in-person while offering to them the flexibility and convenience of being seen remotely for follow-up visits and check-ups and dispensing education for their sexual medicine conditions.

TM also offers providers an opportunity to attract new patients. Today, patients are looking for more convenient ways to access their providers and receive immediate care without going to an emergency room or an urgent care center. There are large numbers of patients who appreciate convenience, flexibility, and real-time care with their providers and such patients often have busy schedules and lifestyles

Table 1. Sexual medicine patients followed using telemedicine

Erectile dysfunction
Hypogonadism (low T and estrogen deficiency)
Premature ejaculation
Peyronie's disease follow-up or after intralesional injection
Male infertility
Lower urinary tract symptoms (BPH)
Follow-up STDs
Discuss reports and imaging studies (PSA, serum testosterone level)
Certain postoperative patients
Follow-up visits to annual examination
New patient interview prior to an in-office visit
Rural patients living at a great distance from the sexual medicine professional
Existing patients who are at a great distance from the brick-and-mortar office

BPH = benign prostatic hyperplasia; PSA = prostate-specific antigen; STDs = sexually transmitted diseases; T = testosterone.

that are similar to those of their providers. Patients who are employed are less willing to waste their time traveling to the office or the clinic and waiting to be seen by the provider. This makes TM very attractive to anyone in the workforce.

Seen from another perspective, the healthcare profession today is increasingly challenging and stressful. More physicians than ever are retiring early or experiencing burnout, which is now at an epidemic proportion of 52% of all physicians.⁷ Unfortunately, urologists have one of the highest burnout rates of all physician specialties.⁸ With more than 50% of practicing urologists over the age of 55 years and nearing retirement, coupled with the rising demand for urological care from aging patient populations, urologists are facing increased pressure to see more patients and spend less time with each one of them.

Telehealth can bridge the gap between physician supply and patient demand. TM can improve job satisfaction by making it easier to interact with patients. Providers can use TM to make it easier to balance their work and family life and perhaps decrease the risk of physician burnout.

BENEFITS OF TM FOR PATIENTS

Sexual medicine patients often seek a provider who is up-to-date with the latest in diagnostic and therapeutic methods of treating sexual medicine diseases. Patients are also interested in providers who are on the leading edge of technology in their practices and whose use of such technology can reduce healthcare expenses. 93% of consumers who have used telehealth say that it has lowered their healthcare costs.⁹

On the other hand, people's biggest concerns about using telehealth services are cost, privacy, and loss of the personal relationship with their doctor.¹⁰ This understanding of what patients look for and seek to avoid in their patient-provider

relationships can help identify those for whom TM might provide an attractive alternative.¹¹

SEXUAL MEDICINE PATIENTS WHO ARE GOOD CANDIDATES FOR TM

Many sexual medicine patients are going to be easily managed using TM. Even patients with sensitive health issues, including erectile dysfunction in men, are potential patients to be managed with TM.¹² Among the best advantages, many of the patients that are typically seen in the office in a face-to-face setting can easily be managed using TM. Table 1 provides a list of patients who can be easily and safely managed using TM.

The guidelines for seeing new patients using TM have not been well-defined. The American Medical Association confirms that TM may be used for all patient visits including initial evaluations in order to establish a provider-patient relationship. The best and safest advice is provided to the patient once in a face-to-face visit or if the provider is consulted by another physician and has received an in-person evaluation by the referring doctor, then the consulting physician can provide care using TM.¹³

It is noteworthy that some postoperative patients will also be amenable for follow-up using TM. Viers et al reported that 28 post-radical prostatectomy patients were followed up using a video visit compared to 27 post-prostatectomy patients followed up in the traditional office visit. The study showed that there were no significant differences in patient safety, confidentiality, efficiency, or overall patient satisfaction. The TM visits incurred lower costs, with a similar level of urologist satisfaction for video visits (88%) and office visits (90%).¹⁴ If post-prostatectomy patients can be safely cared for in the postoperative period, then perhaps vasectomy patients, vas reversals, penile prosthesis, and post-artificial urinary sphincter patients might also be monitored using TM.

SEXUAL MEDICINE PATIENTS WHO ARE NOT GOOD CANDIDATES FOR TM

Conditions that are not suitable for TM are those for which an in-person visit is required to evaluate the patient due to the severity of the problem, the necessity of a physical examination, the need for protocol-driven procedures, or the need for aggressive interventions, such as patients requiring an injection, implantation of testosterone pellets, or in-office procedures. Other patients for whom TM may not be suitable for medical care include those with cognitive disorders, intoxicated patients, language barriers, emergency situations that warrant an office visit or a visit to the emergency room, or who do not have the required technology to conduct a virtual visit.

BARRIERS TO IMPLEMENTING TM

Late adopters often express an assumption that face-to-face visits are the preference of the patients. Also, many practices

are concerned about implementing TM due to the perceived legal and compliance barriers. However, many patients prefer the convenience of a virtual visit.¹⁵ Given the tremendous growth of TM, we are seeing a critical number of patients who will expect that their provider(s) will be able to conduct virtual visits. Practices that don't offer TM are likely to find that patients will seek out a provider who does offer this service.

Already, nearly two-thirds of healthcare professionals expect their commitment to TM to increase significantly in the next 3 years.¹⁶ Of those providers who have not adopted TM, nearly 85% expect to implement TM in the near future.¹⁷ From 2014 to 2018, the adoption of virtual visits has increased in healthcare by 30%.¹⁸

Of course, there is some understandable concern about the cost and the complexity of implementing the TM technology. Unfortunately, the implementation of electronic medical records (EMRs) has left a bitter taste amongst the healthcare communities. EMRs were complicated, expensive, and often resulted in loss of productivity because the learning curve was so steep that doctors had to decrease the number of patients seen before becoming comfortable with the conversion from paper to electronic records.¹⁹

There are going to be practices and providers who will find that using TM will disrupt their workflow or the methodology of managing patients. Implementing TM will require an adjustment on the part of the providers. Providers will have to designate a segment of time that is dedicated to TM and make every effort to be on time for those virtual visits with their patients. Of course, the largest hurdle for most physicians will be providing care and not touching or examining the patient. However, TM implementation is much less onerous and much less expensive. TM is available as a cloud-based platform that requires less IT support and lower levels of hardware and software management. The technology required for patients to participate in TM is nearly ubiquitous. According to Pew Research Center, 96% of Americans own a smartphone and more than half (52%) own a tablet. In essence, the basic requirement to connect patients to providers electronically is already in place.²⁰ From the provider perspective, the basic requirements for implementing a TM program include a computer with video and audio capabilities, and a broadband Internet connection with sufficient bandwidth and speed to view the majority of video encounters in high quality.

Depending on the magnitude of the program, computer technology assistance may be needed to implement TM into practice. It will also be helpful if the TM program is interoperable with the practice's EMR and the practice billing program; if not, double and triple entry will erase the efficiencies provided by conducting a virtual visit.

Like any other aspect of providing patient care, obtaining and documenting informed consent should be practiced with all TM patients. Not only is getting informed patient consent a recommended best practice by the American Telemedicine Association, it is a requirement in many states and/or a requirement for reimbursement, depending on the payer. A sample consent for TM is shown in [Figure 1](#). The National Telehealth Policy

Resource Center provides a state-level map that provides information on the consent requirements in each U.S. state.

Some states have no requirements regarding consent for a virtual visit. Others require verbal consent. In any case, it is a good policy to obtain consent (either verbal or written) and document in the patient's record that a consent was obtained before initiating a virtual visit. The consent should also include the practice's policies regarding billing, scheduling, and cancellations for TM visits.

Since TM is a new way of receiving care for many patients, practitioners and staff must teach patients how the processes and technologies work. Such information should include explanations of patient confidentiality and privacy in the context of virtual doctor visits, the kinds of technical equipment needed for a virtual visit, and the above-mentioned expectations in terms of scheduling, canceling, and billing policies.

Another barrier that must be considered is liability insurance for conducting a virtual visit with a patient. Professionals who are going to offer TM care for patients should request proof *in writing* that the liability insurance policies cover TM malpractice and that the coverage extends to other states, should the patient be physically located in a state different from the state where the provider holds a license. Those who provide TM care also should check with liability insurers for requirements of and limitations on conducting virtual visits with their patients and document such requirements or limitations. For example, a policy may require that the doctor keep a record (either written or recorded) in the EMR of the visit. Consequently, using tools such as Skype, Facebook, or Google, which *do not* include such documentation for the virtual visit, would make those programs less attractive since they do not comply with malpractice liability requirements.

Perhaps the biggest barrier to virtual health adoption is the compensation for the TM visit. The good news is that legislation by most states is quickly embracing virtual health visits (see [Legal Landmines to Consider section](#)).

Finally, a focus on privacy and Health Insurance Portability and Accountability Act (HIPAA) compliance is mission-critical to the success of a TM program. Unfortunately, healthcare has the dubious distinction of being one of the industry's most vulnerable to data breaches and a particular target for hackers. Therefore, it is understandable that, especially in the area of sexual health, professionals are concerned with data privacy, security, and compliance. It is important to recognize that a virtual visit in an office setting or in the home environment could allow fellow employees or family members to overhear the conversations between the healthcare professional and the patient (see additional analysis in the [Legal Landmines to Consider section](#)).

LEGAL LANDMINES TO CONSIDER

The legal and regulatory landscape for the use of TM includes federal and state-specific laws and requirements. It is important

Consent for Telemedicine Services

PATIENT NAME: _____
 LOCATION OF PATIENT: _____ DATE OF BIRTH: _____
 MEDICAL RECORD #: _____ PHYSICIAN NAME: _____
 LOCATION: _____ CONSULTANT NAME: _____
 LOCATION: _____ CONSULTANT NAME: _____
 LOCATION: _____ DATE CONSENT DISCUSSED _____

Introduction

Telemedicine is the delivery of healthcare services when the healthcare provider and patient are not in the same physical location through the use of technology. Providers may include primary care practitioners, specialists, and/or subspecialists. Electronically-transmitted information may be used for diagnosis, therapy, follow-up and/or patient education, and may include any of the following:

- Patient medical records.
- Medical images.
- Interactive audio, video, and/or data communications.
- Output data from medical devices and sound and video files.

The interactive electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Potential Benefits:

1. Improved access to medical care by enabling a patient to remain in his/her physician's office (or at a remote site) while the physician obtains test results and consults with healthcare practitioners at distant/other sites.
2. Obtaining the expertise of a distant specialist.

Potential Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
2. The consulting physician(s) are not able to provide medical treatment to the patient through the use of telemedicine equipment nor provide for or arrange for any emergency care that I may require.
3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
4. Security protocols could fail, causing a breach of privacy of personal medical information.
5. A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other medical judgment errors.

By signing this form, I understand and agree to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telemedicine. No information obtained during a telemedicine encounter which identifies me will be disclosed to researchers or other entities without my consent.
2. I have the right to withhold or withdraw my consent to the use of telemedicine during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment, nor will it subject me to the risk of loss or withdrawal of any health benefits to which I am otherwise entitled.
3. I have the right to inspect all information obtained and recorded during the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. A variety of alternative methods of medical care may be available to me, and I may choose one or more of these at any time. My physician has explained the alternative care methods to my satisfaction.
5. Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.
6. I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. My condition may not be cured or improved, and in some cases, may get worse.

Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of telemedicine in my medical care. I hereby consent to and authorize _____ (name of gynecologist) to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for Patient): _____ Date: _____

If authorized signer, relationship to Patient:

Witness: _____ Date: _____

I have been offered a copy of this consent form (patient's initials) _____

Figure 1. A sample consent form for telemedicine services. Readers may make copies of this consent form and use it with their patients.

to be aware of the laws in each state in which a provider's patients are located, and practice according to the requirements of these laws.

Note that this web of requirements is changing rapidly, in real time and as a result of the COVID-19 pandemic. Beyond current challenges and opportunities—taking a longer view, in other words—TM is becoming more established, and compensation and accountability protocols are being created that reward doctors for care delivered remotely and that align physician responsibility (and potential exposure and liability) with that of other more traditional methods of patient counseling and treatment. Physicians are also better positioned to receive compensation commensurate with the services they provide via TM. Providers treating sexual medicine patients are, in particular, prime candidates to maximize the potential of this technology.

To ensure a smooth transition to or expansion of TM services, physicians and healthcare providers should seek the guidance of legal counsel. A knowledgeable healthcare and TM attorney can help practitioners make the best decisions on the following:

1. *Corporate practice laws.* These laws require that your practice be governed by a healthcare professional, not someone with a non-medical background. This becomes important if one is looking to provide virtual practice in another state.
2. *Collaborative agreement requirements.* These laws require physician supervision of nurse practitioners and physician assistants and may limit the number of allied healthcare providers that a physician may supervise. This is an issue that must be considered, especially if the practice significantly relies on the services of nurses, such as advanced practice registered nurses, who have a broad scope of practice and may be very qualified to care for sexual medicine patients.
3. *Interstate licensing laws.* Certain states may allow for the transfer of practice licenses, or reciprocity, between states; however, there are a number of states that do not, meaning that a provider may need to consider obtaining a license in that state.
4. *State prescription drug monitoring laws.* Every state (except for Missouri) has some form of a prescription drug monitoring program. If you plan to prescribe, you will need to look at that state's requirements for registering in and checking that state's prescription drug monitoring program.
5. *Physician-patient relationship and prescription drug laws.* Drug monitoring laws have expanded to define when you may prescribe controlled substances to a patient. Although state laws may differ, the Ryan Haight Act implemented a requirement that physicians have at least one in-person, face-to-face visit with the patients *before* prescribing them a controlled substance for the first time. State laws may vary, however; it may be best to consult with an attorney to understand your state's requirements for prescribing controlled substances to new patients.

On March 19 and 20, 2020, the U.S. Substance Abuse and Mental Health Services Administration published updated

guidance temporarily waiving certain requirements for the treatment of substance abuse, including opioid use disorder and alcohol or benzodiazepine withdrawal. For example, the U.S. Substance Abuse and Mental Health Services Administration is no longer requiring providers to conduct an in-person evaluation of patients treated with buprenorphine if a program physician has determined that an adequate evaluation can be conducted via TM. (This waiver does not apply to new patients being treated with methadone.) These and other steps have been taken in order to facilitate treatment and reduce infection during the COVID-19 crisis and will likely be terminated once the national public health emergency is suspended.

6. *Telehealth reimbursement.* Reimbursement policies vary by state, region, and payor, and can lead to a very patchwork practice. However, this will likely change over time as payors become accustomed to the demands for telehealth and Centers for Medicare and Medicaid Services (CMS) continues to push for virtual communication with patients. Practices will need to prepare to address the changes in coding and reimbursement changes that are sure to occur.
7. *Data Privacy and Security.* From a content perspective, healthcare data and personally identifiable information are extremely important—which makes electronic health records, or the digital form of patients' medical histories and other data, particularly tempting targets for hackers and cyber criminals. In the first quarter of 2020 alone, more than 120 data breaches—involving the health information of more than 500 individuals per event²¹ and often numbering in hundreds of thousands of patients per breach—were reported to the U.S. Department of Health and Human Services (HHS), as required by the federal Health Information Technology for Economic and Clinical Health Act.

To ensure compliance with HIPAA requirements, providers must establish robust protocols, policies, and processes for handling sensitive information. More recent federal and state laws, such as the California Consumer Privacy Act and the Illinois Biometric Information Privacy Act, also have specific requirements that may implicate healthcare providers and expose them to liability for failure to adequately safeguard protected data, particularly when data are being transmitted, used, and discussed across a wide range of web-based tools, including hardware, software, and applications.

8. *HIPAA compliance.* Generally—and certainly under normal circumstances—TM is subject to the same rules governing protected health information (PHI) as any other technology and process used in physician practices. The HIPAA Security Rule includes guidelines on TM and stipulates that only authorized users should have access to the patient's electronic PHI, that a system of secure communication must be established to protect the security of electronic PHI, and that a system to monitor communications must be maintained, among other requirements. Third parties that provide TM,

data storage, and other services, with a few exceptions, must have a business associate agreement (BAA) with a covered entity. Such an agreement should include specific language that ensures compliance with HIPAA requirements.

During the COVID-19 pandemic, however, certain HIPAA restrictions relating to TM have been temporarily waived by HHS. More specifically, HHS Secretary Alex Azar has exercised his authority to waive sanctions against covered hospitals for non-compliance with rules governing requirements to obtain a patient's agreement to speak with family members or friends involved in the patient's care, to distribute a notice of privacy practices, to request privacy restrictions, to request confidential communications, and the use of non-public facing audio and video communications products, among others. These are temporary measures only; at such time when the national public health emergency is lifted or when the HHS Secretary decides, based on new developments, this position on discretionary non-enforcement will end.

FINDING THE RIGHT VENDOR AND TM SOLUTION

Identifying and implementing an effective, robust TM solution is as important as any other technology decision. A key step in this process is finding a reliable TM vendor—an effort that requires time and due diligence.

One of the best ways to select a vendor is to ask colleagues who have implemented TM and “kick the tires” of their program. It is important to receive feedback from similar practices and find out their experience with the technology. Ask the vendors for referrals from other sexual medicine professionals who have used the program. Speak to doctors and staff, and, if possible, ask for permission to speak to a few of their patients to learn more about their experience with the technology.

The TM program should be interoperable and have a seamless connection between the TM program and the EMR. Such sophisticated programs are more costly but are, in the long run, more efficient and productive than an off-the-shelf tool that functions parallel to or alongside the EMR. The newest programs also have an automated “rules engine” that checks the eligibility of every patient specifically for TM reimbursement as soon as the visit is scheduled. By using a rules engine, if a claim is ever denied and the TM visit was previously approved, the TM reimbursement experts resolve the problem and obtain reimbursement. Essentially, the company ensures a clean TM submission to the payer.

If possible, test the product to ensure ease of use and accessibility on mobile devices, laptops, or home computers. Products today should have a TM app that offers full mobile compatibility, which allows sexual medicine professionals to quickly schedule patients, check patient records, access payment information, and correspond with patients in real time. Arrange a live demo with several vendors so that a clear comparison between programs can be made.

Reputable vendors will have a BAA in place to protect private information. Their software should also be Health Information Trust Alliance certified and HIPAA compliant to meet certain industry standards.

Finally, look for a company that offers reliable customer support. Tech support will be very important, especially when launching the TM program, as all types of issues and questions will occur when installing a new system. Ask about the vendor's customer service and the IT support teams that are available to assist practice, before, during, and after initiating the new technology. Ask the vendor and its previous clients about the promptness of returned phone calls and the page at which they can solve technical problems. Ideally, customer support and information technology teams should be available round the clock.

Be sure your TM vendor provides a BAA. A BAA is a written agreement between a healthcare provider and a contractor/vendor. A provider enters into a BAA with a contractor or other vendor when that vendor might receive access to PHI.

A final key point about vendor and solution selection: TM programs are not one-size-fits-all solutions. A platform that works in one practice may not be applicable to another similar practice. Understand practice needs, processes, and the people who will have some interaction with or responsibility for the tool, look for a telehealth partner who will work with the practice to ensure a program meets all of the requirements, and make decisions accordingly.

CODING FOR TM

Perhaps, the main obstacle to widespread TM adoption for sexual medicine practitioners has been the complexity around reimbursement. Commercial payers and CMS have been slow to enact formal policies for TM reimbursement. Because of this, it is a common misconception that providers cannot be reimbursed for TM appointments, or that compensation is provided at a reduced rate. This makes TM appear economically unappealing to sexual medicine providers.

Beginning March 6, 2020, TM services are no longer considered “optional” coverage in Medicare Advantage Plans for which the patient will be required to pay an additional fee. Instead, the CMS now allows TM as a standard, covered benefit in all plans, enabling beneficiaries to seek care in their homes rather than requiring them to go to a healthcare facility.²²

In the past, TM was restricted for use in rural areas or when patients were at a great distance from their providers. Starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payments for professional services furnished to beneficiaries in all areas of the country in all settings, regardless of the location or the distance between the patient and the doctor. The intention is to offer medical services to patients who may have been exposed to coronavirus or have symptoms of COVID-19 while avoiding the need for such

patients to visit brick-and-mortar offices and risk spreading the disease to staff and other patients. With the expansion of TM services, providers will now be reimbursed for virtual care at the same rate they are for in-person visits.²³

There are also state parity laws that require commercial payers and CMS to reimburse for TM, often at the same rate as a comparable in-person service. Under the new guidelines noted above, reimbursement parity laws are now in place for every state and the District of Columbia. The Center for Connected Health Policy and the Advisory Board Primer are valuable resources that can help providers stay abreast of state-by-state changes in virtual health reimbursement.

As for coding, in particular, as long as the provider performs *and* documents the elements of history and decision making, including the time spent counseling, and documents the visit as if a face-to-face visit occurred, the providers have a billable evaluation and management visit. The 3 main types of virtual services that can be provided to Medicare patients include Medicare telehealth visits, virtual check-ins, and e-visits.

Medicare Telehealth Visits

Currently, Medicare patients may use telecommunication technology for any services that were previously rendered as an in-person communication. The provider must use an interactive audio and video telecommunications system that permits real-time communication between the doctor and the patient at home.

During the current public health emergency, it is imperative that patients with or suspected of having COVID-19 avoid travel, when possible, to physicians' offices where they could risk their own or others' exposure to further illness. The patient must also have a prior established relationship with a provider; however, the new guidelines indicate that HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

Current Procedural Terminology (CPT) coding for virtual visits using synchronous audio/visual communication includes:

99201–99295: office visit for a new patient;

99211–99215: office visit for an established patient.

Important modifiers for TM visits include:

*use modifier 02 for place of service for telehealth Medicare;

*use modifier 95 for commercial payers.

Virtual Check-Ins

Established Medicare patients may have a brief communication service with sexual medicine providers using a telephone or a live video discussion. These brief virtual services, usually 5–10 minutes in duration, are initiated by the patient. The time required for a virtual visit must be documented in the medical record. These virtual check-ins are for patients with an established (or existing) relationship with a physician where the communication is not related to a medical visit within the

previous 7 days and does not lead to a medical visit within the next 24 hours.²³ The purpose of the “virtual check-in” is to determine if an office visit or a test or procedure is indicated.

Medicare pays for these virtual check-ins (or brief communication technology-based services) for patients to communicate with their doctors and avoid unnecessary trips to the doctor's office. These brief virtual check-ins are only for established patients. If, for example, an existing patient contacts a sexual medicine professional for a brief virtual visit to ask a question or to ask if an office visit is necessary, the provider may bill for these brief (5–10 minutes) virtual check-in services, conducted via telephone or other telecommunication devices, using codes G2012 in order to answer a brief question, to determine if an office visit is necessary, or to recommend another service.

E-Visits

Established Medicare patients may have non-face-to-face patient-initiated communications with their provider without going to the doctor's office. These services can only be reported when the billing practice has an established relationship with the patient. The services may be billed using CPT codes 99421–99423.

The coding for these visits is determined by the amount of time the provider spends online with the patient:

99421: online digital evaluation and management service, for an established patient for 5–10 minutes spent on the virtual visit;

99422: 11–20 minutes;

99423: 21 or more minutes.

Given today's circumstances, many doctors will want to immediately start the communication process with their patients and will avail themselves of the free video communication offered by applications such as Google Hangouts, Skype, FaceTime, and Facebook Messenger. Since March 15, 2020, with the relaxation of the HIPAA restrictions for TM, it is now possible to have a virtual visit with a patient using one of these and other free, non-HIPAA compliant connections. The logic behind this change is that such communication methods are no different than the telephone call that has been conducted for decades without any video component.

Using these free technologies, a sexual medicine provider can have an asynchronous visit referred to as a store and forward method of sending information or medical images, which takes place in one direction with no opportunity for interaction with the patient—a video text message left for the patient can be considered an example of an asynchronous visit. On the other hand, a synchronous or real-time video visit with a patient is a 2-way communication that provides medical care without the necessity to examine the patient.

However, there are some downsides to this method of using what we deem “telemedicine-lite” and the free applications that

have grown in use quite recently. First, it must be noted that these virtual visits on Skype, FaceTime, and other non-HIPAA compliant or secure methods are not conducted on an encrypted website. Second, no documentation is prepared for the doctor-patient relationship or interaction. Finally, unless the doctor keeps a record of these virtual visits and submits the interactions to the practice coders, there will be no billing and no reimbursements for the visit. Thus, doctors are not only legally responsible for their decision making, prescription writing, and medical advice, but may also fail to receive compensation for their efforts. A sample documentation form that can be used to record the documentation of the visit that took place is provided in [Figure 2](#).

TRIANGULATION OF THE VIRTUAL VISIT

There are work-arounds that support use of the free programs, protect the doctor, and allow the provider to receive compensation for the virtual visit. One such method is “triangulation” of the virtual visit, which includes 3 necessary parties: (i) the doctor, (ii) the patient, and (iii) the scribe or medical assistant who will record the visit. Before initiating the virtual visit using triangulation, it is imperative to ask the patient for their permission to allow the medical assistant (or any other person in the office who functions as a scribe) to listen to the conversation. In so doing, it is important to provide the reason that a third party is participating in the visit, noting that this person will take notes regarding the visit and then ensure that the notes are entered into the EMR that confirms the documentation process. The scribe or assistant will also record the time, date, and the duration of the visit (documentation requirements for billing purposes) and will then code the visit properly and enter it into the practice management system so that a bill is submitted to the insurance company. At the end of this process, the provider will have documentation that consent was obtained, that the visit took place, that notes were made, and that the patient’s insurance company should be billed for the visit.

Triangulation can offer legal protection, should physicians choose to use one of the free, non-HIPAA compliant solutions, and provides an opportunity to capture all of the reimbursements that would be owed—generating increased efficiencies and productivity ([Figure 2](#) provides a sample documentation form).

COMMON CPT CODES APPROPRIATE FOR SEXUAL MEDICINE PROVIDERS IN THE OUTPATIENT SETTING

A good rule of thumb for the use of CPT codes is to use the same codes that would be used for an in-person appointment. For TM services in general, one would code as for any regular outpatient, face-to-face visit, using CPT codes 99211–99215 for an established patient visit and 99201–99205 for a new patient visit.

Virtual Visit Documentation Form

Date ____/____/____ Time Start ____ a.m./p.m.
 Total Time of Visit ____ min.

Patient Information
 First Name _____ Last Name _____
 DOB ____/____/____ Phone _____
 Gender _____ Email _____
 Mode of Communication
 Telephone Text Video Chat Instant Messenger Other

Diagnosis _____
 Aetiology _____
 Symptoms _____

Clinical Findings _____

Prescriptions Provided _____

Treating Provider _____
 Signature _____
 CPT CODE _____ DATE ENTERED IN EMR ____/____/____
 INITIALS _____



Figure 2. Suggested documentation form for telemedicine visits (used with permission from Vanguard Communications). CPT = Current Procedural Terminology; DOB = date of birth; EMR = electronic medical record.

These are the most common CPT codes for outpatient office visits either in a face-to-face or a synchronous virtual visit, that is, via a real-time interactive audio and video telecommunications system.

As an example, for a sexual medicine encounter using TM, the reimbursement for 99213 ranges from \$73 to \$100. The challenge is to achieve the complexity requirements for a level 3 office visit without a physical examination. The documentation for these encounters, whether they are face-to-face or virtual visits, requires 2 of 3 of the following components:

1. Expanded Problem Focused History;
 2. Expanded Problem Focused Examination (not accomplished with TM);
 3. Low Complexity Medical Decision Making;
- or
- at least 15 minutes spent face-to-face with the patient if coding is based on time.

Pursuing the above example further, if a provider reviews results of a recent laboratory test for a testosterone-deficient patient and adjusts the testosterone dosage, sends a prescription to the patient’s

pharmacy, and spends 15 minutes on communicating with the patient, this visit meets the complexity requirements for 99213. Since level 4 and 5 office visits (99214 and 99215) require a comprehensive physical examination, it is necessary to document the time spent with the patient, that is, 99214 requires 25–39 minutes of consultation and 99215 requires 40 or more minutes.

It should be noted that, as a direct result of the coronavirus pandemic, 80 new telehealth codes have been added temporarily, along with expanded billing and coding. However, we do not believe that all of these changes will be made permanent before or at the point at which the national health emergency is declared to be over. In the interim, we believe that it is best practice to follow the coding indications as described in this article. It is also imperative to contact a healthcare attorney well versed in coding issues to ensure that billing and coding compliance is maintained.

CONFIRM TM SERVICE PROVIDER BILLING GUIDELINES

Irrespective of the TM service used, it is important to confirm the TM billing guidelines *before* engaging patients with TM visits. Consider starting the call to the payer and confirm that the payer provides parity between TM visits and face-to-face visits. Then ask which specific billing codes should be used.

Until physicians and their practices become comfortable with TM—and while developing the necessary experience with coding and billing for TM service—we recommend that practices use a TM platform that includes a rules engine that offers recommendations for each TM visit based on past claims data. Such rules engines help sexual health providers determine which CPT code is to be used and identify the appropriate modifiers for the various insurance companies. The value of a rules engine is that it supports submission of a clean claim that is less likely to be denied and very likely will be paid. There are some vendors who are so confident that their rules engine will match the service with the proper CPT code and proper modifier, that the vendor guarantees full private payer reimbursement for TM visits, or the vendor will reimburse the claim.

GETTING STARTED

We suggest that providers consider a pilot trial with a few patients and staff in order to become comfortable with the new technology and then expand usage based on the feedback they provide. If possible, a face-to-face visit should precede a TM visit which should include a comprehensive physical examination.

Ultimately, TM is here to stay. Those professionals who do not communicate with patients using TM may find that their practices are antiquated and might suffer an attrition of existing patients.

We believe that the traditional face-to-face interactions with sexual medicine patients are not going to completely disappear. Nothing can replace the supreme importance of an in-person face-to-face visit with a trustworthy, well-respected physician. However, we hope to have demonstrated that there is going to be a seismic shift from face-to-face to face to computer-assisted encounters in the immediate future.

CONCLUSION

Contemporary sexual medicine practices must consider the implementation of TM. Failure to do so will likely see an erosion of patients, many of whom will migrate to practices that offer TM. In spite of insurance and government interference, there has been a steady—and, at present, explosive—rise of TM. There are significant numbers of patients who want to consult sexual medicine professionals via ubiquitous communication technologies such as teleconferencing and email. Sexual medicine is one of the areas of healthcare that is primed for the incorporation of TM into practice. The “proverbial puck” of sexual medicine patients is going to be in the hands *and the computers*. of the professionals who embrace TM.

Corresponding Author: Neil Baum, MD, Tulane Medical School, Department of Urology, 3525 Prytania, Suite 614, New Orleans 70115, LA, USA. Tel: +1 504 339 0535; Fax: +1 504 861 2870; E-mail: doctorwhiz@gmail.com

Conflict of Interest: Anjali Dooley is a managing partner of the Law Office of Anjali B. Dooley, LLC. Nadia de la Houssaye is a partner in the law office of Jones Walker, LLP. Dr Neil Baum reports no conflicts of interest.

Funding: None.

STATEMENT OF AUTHORSHIP

Category 1

(a) Conception and Design

Neil Baum; Anjali Dooley; Nadia de la Houssaye

(b) Acquisition of Data

Neil Baum; Anjali Dooley; Nadia de la Houssaye

(c) Analysis and Interpretation of Data

Neil Baum; Anjali Dooley; Nadia de la Houssaye

Category 2

(a) Drafting the Article

Neil Baum; Anjali Dooley; Nadia de la Houssaye

(b) Revising It for Intellectual Content

Neil Baum; Anjali Dooley; Nadia de la Houssaye

Category 3

(a) Final Approval of the Completed Article

Neil Baum; Anjali Dooley; Nadia de la Houssaye

REFERENCES

1. American Urological Association. 2016 AUA annual census. American urological association web site. Published 2016. Available at: <https://www.auanet.org/research/aua-census.cfm>. Accessed September 13, 2016.
2. Kent J. Research shows telehealth service use on the rise. *Telehealth News*, March 26. <https://mhealthintelligence.com/news/research-shows-telehealth-service-use-availability-on-the-rise>. Accessed July 22, 2020.
3. Bryant M. Kaiser permanente CEO reports strong use of telehealth. Available at: <https://www.healthcarediver.com/news/kaiser-permanente-ceo-reports-strong-use-of-telehealth/441140/>. Accessed July 22, 2020.
4. Telehealth index: physician survey. Available at: <https://static.americanwell.com/app/uploads/2019/04/American-Well-Telehealth-Index-2019-Physician-Survey.pdf>. Accessed July 22, 2020.
5. Lagasse J. Telemedicine is poised to grow as its popularity increases among physicians and patients. *Healthcare finance*. July 16. Available at: <https://www.healthcarefinancenews.com/news/telemedicine-poised-grow-its-popularity-increases-among-physicians-and-patients>. Accessed July 22, 2020.
6. Berwick DM, Nolan TW, Whittington J. The triple aim: care, health, and cost. *Health Aff* 2018;27:759-769.
7. Shanafelt TD, Dyrbye LN, West CP. Addressing physician burnout: the way forward. *JAMA* 2017;317:901-902.
8. Physician burnout in 2019, charted, The Advisory Board Company. Available at: <https://www.advisory.com/daily-briefing/2019/01/18/burnout-report>. Accessed July 22, 2020.
9. 2016 HealthMine digital health report: state and impact of digital health tools, HealthMine. Available at: https://healthmine.com/wp-content/uploads/2019/07/HealthMine_Digital_Health_Tools_Report_May_2016.pdf. Accessed July 22, 2020.
10. Varshneya R. 7 telemedicine concerns and how to overcome them. Available at: <https://telemedicine.arizona.edu/blog/7-telemedicine-concerns-and-how-overcome-them>. Accessed July 22, 2020.
11. Wilson EV, Lankton NK. Modeling patients' acceptance of provider-delivered e-health. *J Am Med Inform Assoc* 2004; 11:241-248.
12. Wicklund E. Telehealth offers a platform for discussing sensitive health issues. December 29, 2017, Available at: <https://mhealthintelligence.com/news/telehealth-offers-a-platform-for-discussing-sensitive-health-issues>. Accessed July 27, 2020.
13. 50-state survey: Establishing of a patient-physician relationship via telemedicine, Available at: <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>. Accessed July 27, 2020.
14. Viers BR, Lightner DJ, Rivera ME, et al. Efficiency, satisfaction, and costs for remote video visits following radical prostatectomy: a randomized controlled trial. *Eur Urol* 2015;68:729-735.
15. Dixon RF, Stahl JE. Virtual visits in a general medicine practice: a pilot study. *Telemed J E Health* 2008;14:525-530.
16. Welch BM, Harvey J, O'Connell NS, et al. Patient preferences for direct-to-consumer telemedicine services: a nationwide survey. *BMC Health Serv Res* 2017;17:784.
17. Tsai JM, Cheng MJ, Tsai HH, et al. Acceptance and resistance of telehealth: the perspective of dual-factor concepts in technology adoption. *Int J Inf Management* 2019;49:34-44.
18. Kahn JM. Virtual visits—confronting the challenges of telemedicine. *N Engl J Med* 2015;372:1684-1685.
19. Patil M, Puri L, Gonzalez CM. Productivity and cost implications of implementing electronic medical records into an ambulatory surgical subspecialty clinic. *Urology* 2008;71:173-177.
20. Pew Research Center, Internet and technology. Available at: <https://www.pewresearch.org/internet/fact-sheet/mobile/>. Accessed July 22, 2020.
21. HIPAA Breach news-HIPAA Journal. Available at: www.hipaajournal.com/category/hipaa-breach-news. Accessed July 27, 2020.
22. Sweeping regulatory changes to help U.S. healthcare system address COVID-19 patient surge. Available at: <https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient>. Accessed July 22, 2020.
23. Medicare telemedicine health care provider fact sheet. Available at: <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>. Accessed July 27, 2020.