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Editorial

Innovation Through Regulation: COVID-19 and the Evolving Utility of Telemedicine

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A year ago, a group of AMDA leaders spent the day on Capitol Hill advocating for policy changes related to post-acute and long-term care (PALTC) telemedicine. A main point of discussion was the need to revise the regulations governing payment for telemedicine visits in a way that would make it more feasible for PALTC clinicians working with facilities to use telemedicine tools to care for residents. Medicare payment for telemedicine physician visits has largely been to support rural nursing homes and limited to no more frequently than monthly regardless of medical necessity. These restrictions have made it very difficult for PALTC clinicians to make the business case to include telemedicine into most clinicians' practice. Telemedicine to date had largely been supported directly by nursing homes that arrange for afterhours and weekend coverage to manage changes of condition with the primary goals of reducing potentially avoidable emergency department visits and hospitalizations. Telemedicine had also been frequently used for certain subspecialties including behavioral health, wound care diagnosis and management.

One year later, as a result of rapid policy changes in response to the COVID-19 pandemic, much has changed. Rational changes in regulations guiding telemedicine in nursing homes and the need for thoughtful infection prevention have inspired a new opportunity for innovation and vision for how high-quality care can be accessed in nursing homes.

The Case for Telemedicine

Many factors combine to make nursing homes an ideal venue for telemedicine. The population of patients in nursing homes has steadily increased in complexity, creating the need for timely and skilled acute and chronic care from clinicians with competency in PALTC. In contrast to medical providers working in hospitals, emergency departments, and primary care practices, PALTC clinicians may only be onsite in the nursing facility intermittently and rarely during nights and weekends. This translates into challenges around change of condition assessment and can contribute to misdiagnoses, delays in diagnosis, and overuse of emergency departments. PALTC clinicians and medical directors have believed for many years that their patients would benefit from telemedicine tools to increase access.[1,2] A growing abundance of feasibility studies exploring the application of telemedicine in nursing homes has also supported the concept. In early 2019, AMDA's Workgroup on Telemedicine and Technology published a white paper offering guidance to clinicians and facilities on the use of telemedicine to deliver medically necessary evaluation and management of change of condition for nursing home residents.[3] The paper reviewed the many research studies and published case reports that demonstrate the ability of telemedicine interventions to reduce avoidable emergency department visits and hospitalizations. In this issue of *JAMDA*, the GeriCare@North example also demonstrates the feasibility of deploying acute geriatric medicine consultation via telemedicine for a variety of routine and symptom-based concerns to nursing home residents in Singapore.[4]

The COVID-19 pandemic has highlighted the need to provide timely access to high-quality medical care, especially to nursing home residents with new or worsening respiratory symptoms. The benefits of telemedicine allow for actual or suspected COVID-19−positive residents to be treated in place when their care plan goals support this (ie, goal-concordant care). This concept, called forward triage, can allow for resident assessment in the nursing home using telemedicine to optimize survival and resources, while reducing the risk of community spread and limiting exposure of other health care personnel to COVID-19.[5]

Regulatory Changes Due to COVID-19 Change the Landscape

In their March 2020 response to COVID-19, the US Center for Medicare & Medicaid Services (CMS) has essentially removed the biggest financial barriers to PALTC clinicians providing telemedicine services in the nursing facility. In a sweeping interim final rule issued at the end of March, CMS removed the once-a-month limitation for

Table 1
AMDA–The Society for Post-Acute and Long-Term Care Medicine Guidance for Submitting Claims for Telehealth Services During COVID-19 in the Nursing Home Setting to Reflect

COVID-19 Telehealth Waivers
• Originating sites (where nursing home residents are located) no longer need to be in rural locations as defined by the Health Resources and Services Administration (HRSA) during any portion of any COVID-19 public health emergency period
○ Nursing homes can bill Q3014 as an originating site (payment approximately $26 per encounter)
• Post-acute and long-term care clinicians do not need to demonstrate prior relationship with the patient, ie, at least 1 encounter in the past 3 years by the same provider or other qualified provider in the same practice (as determined by tax ID)
• Changes and clarification to distal site (where the qualified practitioner is located) requirements are as follows:
○ For practitioner doing the visit:
- Use appropriate CPT E&M nursing facility code (99304-99310, 99315/16)
- Use appropriate Place of Service (POS) Code: 31, skilled nursing facility; 32, nursing facility
- Use modifier 95 to indicate visit done via telehealth
- Conduct telehealth visits "as appropriate"
- Initial visit (99304-99306) can be completed by physician assistant/nurse practitioner during the public health emergency
- Must obtain consent from patient or designated surrogate (can be verbal) for conducting telehealth visits
- Can waive any copay associated with the visit

CPT, Current Procedural Terminology; E&M, evaluation and management.
Adapted from https://paltc.org/telehealth-paltc (accessed June 5, 2020).

subsequent care visits (CPT 99307-99310) and added initial visits (CPT codes 99304-06) and discharge services (CPT 99315-16) to the list of Medicare reimbursable telehealth services. Essentially, the agency suspended all face-to-face regulatory visit requirements and allowed them to be completed using telehealth tools. Further, the agency announced that these visits will be paid at the same rate as a face-to-face visit even if completed via telehealth.[6,7] Other codes that are now reimbursable are listed in Table 1.

Importantly, also removed was the limitation of telemedicine reimbursement for only rural nursing homes. Regulations previously restricted reimbursement to rural nursing homes as originating sites (the location of the patient at the time the service is furnished via a telemedicine). Under the public health emergency waiver, clinicians originating care for residents located in *either* rural or urban nursing homes can bill for eligible encounters delivered via telemedicine tools. PALTC practitioners at the distant site who may furnish and receive payment for covered telemedicine services, also referred to as distal site practitioners, complete their billing documents with appropriate E&M codes, place of service where the service took place, and modifier 95 indicating a telemedicine visit. Supplemental funding through the Federal Communications Commission was also made available to health care centers seeking to expand their capacity to provide virtual care, further reducing barriers to telemedicine-based care.[8] Governmental discretion to not enforce penalties for Health Insurance Portability and Accountability Act (HIPAA) violations on health care providers using telemedicine tools in good faith to deliver care during the COVID-19 pandemic has allowed more health care providers to try using telemedicine tools without the burden of complex technology and program initiation costs. However, privacy concerns will likely resurface as we deal with the aftermath of the pandemic. In separate rulemaking just prior to the COVID pandemic, the Office of the National Coordinator (ONC) released a long-awaited interoperability final rule dealing with a plethora of issues including cybersecurity. There will be an ongoing need for the ONC to address concerns about privacy and security as telehealth use expands.[9] For now, public health emergency waivers have enabled every PALTC medical provider and facility to try adding telemedicine to their care delivery toolkit. Telemedicine programs are reporting significant growth.

Health care's relationship with telemedicine has the opportunity to be forever changed as a result of the COVID-19 global pandemic. During the pandemic, health systems across the United States have exponentially expanded care via telemedicine to nursing home residents. For example, at the University of Rochester, between March and May 2020, telemedicine visits between the medical providers of our

Table 2
Recommendations for Incorporating Enhanced Telemedicine in Long-Term Care Practice After the COVID-19 Pandemic

Recommendation	Action
Regulatory reform	• Allow Medicare payments to post-acute and long-term care clinicians for all skilled/nursing facility CPT E&M codes using telehealth
	• Allow medical necessity to dictate telemedicine visit frequency for subsequent care visits
	• Allow nursing homes to receive facility fees for all telemedicine encounters regardless of physical location
	• Expand billable telemedicine services for nursing home residents to include e-consultation and additional remote patient monitoring
	• Ensure payment parity between face-to-face and telemedicine care in Medicare and third-party payors
Evaluate the impact of telemedicine on nursing home structure, process, and outcomes	• Develop and assess the impact of PALTC workforce competencies for both originating and distal site providers who use telemedicine tools on clinical outcomes
	• Refine and assess the use of telemedicine for forward triage on clinical outcomes
	• Evaluate how regulatory visits delivered by telemedicine vs face-to-face impact the quality of clinical care and provider or resident satisfaction
Technology	• Collaborate with telemedicine service providers to develop cost-effective, low-bandwidth, accessible, and easy-to-use telemedicine technology
	• Work with cellular service and Internet service providers to deliver high-speed, low-cost Internet access, to support telemedicine and communication technologies in nursing homes
	• Collaborate with electronic medical record vendors to improve access to and documentation within various information systems during telemedicine visits
	• Increase the number of easy-to-use, low-cost Health Insurance Portability and Accountability Act (HIPAA) security–compliant telemedicine tools available to post-acute and long-term care providers.

CPT, Current Procedural Terminology; E&M, evaluation and management.

geriatrics group that cares for residents of several nursing homes went from being a rare occurrence to the group completing approximately 250 telemedicine visits a week, representing about a third of the practice's nursing home encounters. The Veterans Health Administration, a longstanding leader in adoption of telemedicine in health care, moved to create telemedicine access for nursing home residents in all of their Community Living Centers. As we ride the momentum of change, it is important for us to continue to expand our understanding of how telemedicine tools are best used in care. The interconnected relationship between patient population, the reason for the medical visit, and the modality of telemedicine used needs to be further refined for us to deliver the highest-value care. Many have hypothesized that telemedicine should not replace the face-to-face regulatory care visits and medically necessary visits that form the foundation of primary care in the nursing home. Our experiences in COVID-19 may change our perspective on that question.

Can we embrace the disruption of the pandemic and use it to drive other programmatic innovations in post-acute long-term care? As we move beyond the initial COVID-19 storm to a new, improved way of providing care in nursing homes, strategic action is needed to more permanently resolve the issues that may limit our progress (Table 2). The integrated health network of Eastern Ontario has demonstrated the feasibility of using e-consultation for specialty care such as dermatology and infectious disease and identified perceived value with respect to timeliness, quality of care, and cost.[10] Similarly, investigators in the AMDA Telemedicine workgroup conducted a study of the perceived value of subspecialty telemedicine that showed that dermatology, geriatric psychiatry, and infectious disease were the specialties that PALTC practitioners would consult the most if available.[11] Similarly, many have called for reimbursement models to further expand reimbursement for telemonitoring and other telephonic-based care modalities. Now is the time to quantify the cost, quality, and value of these types of clinical services. When we look back, years from now, what will PALTC practitioners have learned about effective care delivery using telemedicine technology? Hopefully, we will see 2020 as the turning point in our understanding of how to build effective, financially stable medical care models, that leverage telemedicine technology effectively to deliver the right care, at the right time, in the right place, to the right patient.

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