Health Law Connections

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Telemedicine: From Face-to-Face to Cyberspace

As the COVID-19 pandemic evolved, it altered the way providers approached the provision of care, and telehealth and telemedicine became critical components of health care delivery. While the terms are often used interchangeably, there is a notable distinction between the two: telehealth refers to the overarching concept of health-related services being managed by some sort of electronic information exchange, whereas telemedicine involves actual clinical care delivery remotely. Most patients are familiar with, and have used telehealth services in some fashion, via smart phone applications, online patient portals, e-visits, or text updates. Through these mechanisms, patients can access lab results, schedule appointments, receive notifications, and conduct limited electronic health check ins. Telemedicine, however, has only been used in limited circumstances prior to the pandemic despite having been around for decades. In fact, telemedicine progressed forward more rapidly in the past two months, than in the past 20 years. Prior to the pandemic, only an estimated 1 in 10 Americans had utilized telemedicine services, with the low volume attributable to two major factors: (1) physician and patient apprehension, and (2) difficulty in obtaining reimbursement. Medicare rarely reimbursed telemedicine services pre-pandemic and did so under extremely limited circumstances. Due to the current crisis, telemedicine has become a necessity to protect vulnerable populations, to slow the spread of the virus, and to increase access to care by enabling COVID-19 positive providers to continue seeing patients.

Effective March 6, 2020 through the end of the COVID-19 public health emergency, a telemedicine services expansion waiver for Medicare was issued under the Section 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. The waiver relaxed restrictions for telemedicine services across four broad categories: location, technology, services, and reimbursement. These significant changes resulted in a dramatic increase in the volume of virtual services, that in turn, resulted in both opportunities and risks for providers.

**Location:** Rural restrictions were removed enabling patients in areas other than professional health shortage areas to receive care remotely. Site restrictions that required both the physician and patient to be present in an approved location were also waived, allowing patients to remain in their own homes and physicians to provide services at their desired location. This is a significant change from previous restrictions that required patients to travel to an approved location, typically a critical access hospital, and the physician to be based in a similar approved location. With the loosened restrictions, the Health Insurance Portability and Accountability Act (HIPAA) is and will remain a compliance concern over the long-term.

**Technology:** Use of only HIPAA-approved audio/visual devices became moot as patients no longer left their homes to obtain care. Relaxation of the technology requirement enabled both patients and physicians to use their smart devices with guidance to providers to use discretion when conducting a remote visit. For example, if in a physician lounge, care should be taken to ensure that the smart device is shielded from others, conversations conducted quietly, and patients are notified that their protected health information may be witnessed by others. Compliance risk will increase significantly as verification of actual patient identity could prove challenging in new patient situations. Effective April 30, 2020, the Centers for Medicare & Medicaid Services further relaxed the video requirement as many older patients do not have access to smart devices. This bold step toward expanding care to as many vulnerable patients as possible will help prevent the spread of infection but also will increase compliance risk significantly as verification of actual patient identity could prove challenging.

**Services:** Pre-pandemic, only patients already established with a medical practice could be seen remotely, and only certain services were covered. Under the waiver, patients who are new to the practice can be seen, and multiple covered services were approved for remote visits, including behavioral health, physical therapy, and others. Supervision requirements that previously restricted non-physician practitioners from performing telemedicine services have now been lifted to allow...
virtual visits to be performed without the supervising physician immediately available. The benefit of increased services presents a certain degree of risk as the amount of interaction with new patients is more limited, and non-physician practitioners are providing services without real-time supervision.

In addition, the waiver relaxed licensure requirements, allowing physicians to continue seeing patients on expired licenses, and to see patients in diverse geographical locations and across state lines. Enrollment applications that previously took several months to process are now being conducted telephonically with approvals in real time. From a compliance perspective, relaxing regulations such as these could possibly open the door to dishonest behavior.

Reimbursement: Under the waiver, Medicare will reimburse telemedicine visits as if they were face-to-face, and co-payments or cost shares will be waived for both COVID-19 and non-COVID-19 visits. Nevertheless, providers are still required to maintain proper documentation of telemedicine visits. Poor documentation may result in improper payments or overbilling for services, such as e-check ins inapropriately billed as evaluations.

While the waiver is only effective until the public health emergency is declared over, many elements are expected to remain, though with heightened oversight. It is unlikely, for example, that site restrictions will be reinstated, but there will most likely be new restrictions around internal controls, HIPAA, and documentation requirements. In terms of technology, there will likely be restrictions put in place around the use and security of personal devices. New and established patient visits will likely continue virtually for less acute illnesses and injuries but will need to resume face-to-face for more acute problems requiring an exam or treatment. There also is a very low likelihood that payers will continue to reimburse office visit rates for virtual visits.

Compliance Challenges. All providers submitting claims to government payers will need overall compliance program revisions to incorporate new policies and procedures, new education and training for clinicians and coders, enhanced auditing and monitoring, and structured communication plans. Technology will need upgrading to compliantly accommodate virtual care delivery including electronic health record templates, charge masters, and fee schedules. Patient protocols and decision trees will need to be developed for scheduling virtual visits versus live visits in terms of safety and risk. Government audits are sure to resume, focusing on telemedicine services and the inherent associated risk of overbilling and fraud and abuse. Reductions in payments for evaluations done remotely will significantly impact operating income, and health care organizations of all sizes will be forced to reevaluate strategic planning, practice management efforts, volume projections, and patient retention efforts. Post-pandemic, compliance efforts will need to resume in order to ensure proper licensure and thorough provider review processes.

Along with the technological advances in care delivery comes the associated risk of fraud and abuse. Post-pandemic, it is inevitable that physician visits will not return to over 90% being performed face-to-face. Health care providers will have an opportunity to reassess the way in which they do business and how they will mitigate the resulting compliance risk to the lowest possible levels. With both patients and providers in non-structured environments it will be increasingly challenging to monitor the occurrence of actual visits, existence and completeness of medical record documentation, adherence to revised HIPAA regulations, continuity and coordination of care, and e-prescribing. Physicians transitioning from an office-based setting to doing business on handheld devices will need to be even more meticulous about documentation, treatment plans, and patient orders. The golden rule of “not documented, not done” will take on greater significance than ever before, as something lost in cyberspace cannot be recovered may result in negative impacts to the practice, potential improper payments, and quality of care issues. Without a doubt, telemedicine during and post pandemic will be the catalyst that drives digital health care for the future. Compliance professionals will need to pivot, and shift thought leadership to accommodate this exciting new standard in care delivery.