AMA Innovations in Medical Education Webinar Series
Engaging learners in telemedicine visits: workflows to support teaching, feedback and billing

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Julian Genkins, MD
Eric Johnson, MD
Benjamin Li, MD
Sherry Smith, MS, CPA
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Today’s Host

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American Medical Association

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University of Michigan Medical School

@Maya_Michigan
Objectives

- Consider strategies to incorporate telemedicine as a core element of the clinical curriculum at your institution
- Describe the typical flow of a telemedicine encounter and points at which learners can be engaged, from the perspectives of both supervising faculty and resident physicians
- Discuss key faculty development needs to promote active teaching - importantly assessment and feedback – during such encounters
- Review AMA guidance regarding issues of privacy, billing and documentation
ACCELERATING CHANGE IN MEDICAL EDUCATION

Presenter

Eric Johnson, MD
Associate Professor, Family & Community Medicine
University of North Dakota School of Medicine and Health Sciences
Presenter

Julian Genkins, MD
Resident Physician, Medicine
University of California, San Francisco
ACCELERATING CHANGE IN MEDICAL EDUCATION

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Benjamin Li, MD
Resident Physician, Radiation Oncology
University of California, San Francisco
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Sherry Smith, MS, CPA
Director Physician Payment, Policy and Systems
American Medical Association
Telehealth Workflow and Learner Interaction

Eric L. Johnson, M.D.
Eric L. Johnson, M.D.

- M.D. University of Nebraska Medical Center
- Family Medicine Residency University of North Dakota-Fargo program
- Associate Professor, University of North Dakota School of Medicine and Health Sciences
  Grand Forks, ND
  - Department of Family and Community Medicine
  - Department of Education Resources
  - Director, Interprofessional Education
  - Medical Director, Physician Assistant Program

- Assistant Medical Director, Diabetes Center at Altru Health System, Grand Forks, ND

- Chronic Disease Prevention and Management Committee- AMA
- Chair, Primary Care Advisory Group- ADA
Practice Setting

• Service area of about 250,000 extending from north central North Dakota to north central Minnesota
• Small system, over 10,000 telehealth visits a year
• Full service team based diabetes center at Altru Health System
• 30% clinic time, all diabetes care, many type 1 using technology-pumps, continuous glucose monitors, phone apps
• Prior to COVID-19 outbreak, 30% of visits were scheduled classic telemedicine facility to facility with several smaller clinics in the region-majority based in Rugby, ND about 150 miles away.
• Some patients drive 100-150 miles to get to that telemedicine site
• Manage a lot of digital information from continuous glucose monitors emailed or posted to third party websites available to certified diabetes educator or myself
• I have been doing telemedicine visits for 7 years
• Post-COVID-19, 100% telehealth visits
• I’m high risk, most, if not all diabetes patients are high risk
Post-COVID-19

- Persons with diabetes are known to be high risk. Patient acceptance was nearly immediate
- Relaxation and modification of billing and coding rules have made this a viable option
- Patients will likely continue to demand this service in the future
- Going back to “normal” seems unlikely
- Still need to consider some elements that must be done in person (i.e., comprehensive foot exams)
- Some kind of blend of virtual and in person
Post-COVID-19 Telehealth Learning

• Some of our students and residents have been thrust into telehealth environments quickly—students mostly observing at this point
• We had already started doing some telehealth teaching in pre-clinical years with an AMA grant—Remotely Operated Biomedical Telepresence Systems (ROBOTS) about 3 years ago
• Some focus on what makes an engaging quality visit
What makes a good visit?

• Avoid distractors in the video frame (eating, drinking, on phone, looking around, distracting movements)
• Must be in a private space (don’t do your visit at a coffee house)
• Look into the camera to create illusion of eye contact, keep that comfortable
• Project voice “through” the microphone
• Sit up straight
• Good lighting
• Dress professionally as if you were in clinic
• “Frame the shot”
• If on phone, have someplace stable, moving around very distracting for the patient
• You are creating an experience, not just a video call
• Follow best practices (AAMC, AMA, AAFP, etc), credentialing, licensing, HIPAA
So close.....

Background is completely neutral-good!
Lighting is good!
(May not be possible, but may be ideal)
Drinking coffee! No! That’s distractor
Typical visits we are doing now from our diabetes clinic

Virtual Visits - device to device usually patient is in their home

Classic facility to facility telemedicine
Typical patient flow for a telehealth visit - I can do these from home

Encounter “occurs” where patient is located

- Telemedicine - patient in clinic - very much like a regular clinic visit
  - Check in at reception at clinic in a remote site
  - Nurse or medical assistant gets vitals, reconciles medications, data management, etc
  - Interact with patient
  - Nurse or medical assistant stays in room for at least part of the visit to facilitate communication and engage with physician extender devices (stethoscope, opthalmoscope, otoscope, etc)
  - Charting similar to clinic visit
Typical patient flow for a telehealth visit -
I can do these from home
Encounter “occurs” where patient is located

• Virtual (Video) visit-patient is on device to your device-usually from their home
  • Patient electronically “checks in”- can do through electronic health record, secure password protected zoom meeting etc
  • Have the patient weigh themselves and check blood pressure if possible
  • Data available in advance if possible (remote cardiac monitoring, continuous glucose monitoring data, etc)
  • Select patients may have electronic stethoscope or other extenders
  • Charting similar to clinic visit
• I prefer split screen- looking in the right direction while charting, reviewing data, writing orders, etc
• Can do on multiple screens
What are we doing to educate learners?
Focus on Interprofessional Care

Rural vs. Urban Settings

Urban
- Collocated specialties and professionals in a single facility
- Easier access, including IP team rounds

Rural
- Fewer personnel and specialties on-site
- Access to professionals is complicated by distance and technology

Telehealth
- Can solve distance problem
- Creates additional challenge/required skillset for Interprofessional education and collaboration
Solution: Project ROBOTS

Remotely Operated BiOmedical Telepresence Systems

Three-part IPE simulation scenario

- 5 professions
- Longitudinal continuity of care for myocardial infarction (MI) patient over time
- American Medical Association grant, Dr. Richard Van Eck and Dr. Jon Allen, co-PI’s, Dr. Eric L. Johnson telehealth consultant and instructor
Setting and Process

- Collaborative agreement on objectives
  - 5 disciplines
  - 3 colleges
  - Focus on communication and collaboration using telehealth
- Adapted from required medical cardiac simulation curriculum
- This is now a required simulation
Scenarios

Emergency room

- Chest pain/pressure center of chest
- Eventually diagnosed with MI

IP team

- Nurse, physician (in-person, telemedicine), “cardiologist” (facilitator, via telemedicine), social work, physical therapy, occupational therapy
- Medical students receive and generate telemedicine care
- All get an introduction to telehealth basics

Treatment

- Transport to regional health center with cath lab
- Coronary stent placed
- Discharge to home town with no cardiac rehabilitation
- Eventual long term care placement
On-boarding students and residents in the clinic

• Many platforms allow more than 2 parties (Zoom, Microsoft teams, other proprietary systems)- can all be at their own sites

• Scenarios
  • Student, resident, physician can all make introductions at beginning of visit or in any order. EHR can be accessed remotely by any/all (if possible- may vary by institution)
  • Can be on for all or part of visit
  • Student, resident, physician can come and go from more than one patient
  • Be fluid, work as a team
  • Have a plan to document, make the most of your EHR with smart phrases, templates, etc
  • Who is closing out the visit?
University of North Dakota
School of Medicine and Health Sciences
Psychiatry Residents Telehealth Experience

• Have been doing this model for a few years
• Serves our rural state well
• 3rd and 4th year residents- have developed some clinical competency
• At Southeast Human Service Center site (Fargo), attending not required for evaluation/followup
• Residents video call or email attending with treatment plan
• Final orders transmitted to patients by phone, messaging, etc
• Must have a plan in place for emergency holds, etc (i.e., local law enforcement)
Summary

• Know your team
• Understand the technology available to you
• Any data you can have in advance will improve efficiency
• I view this as an opportunity for all of us to get better with telehealth—we were going that way anyway
Engaging Learners in Telemedicine Visits: The Trainee Perspective

Julian Genkins, MD & Ben Li, MD, MBA
Resident Physicians
University of California San Francisco
Our Background

Benjamin Li is a PGY3 Radiation Oncology resident at UCSF interested in global health, telemedicine, and virtual education.

Julian Genkins is a PGY3 internal medicine resident at UCSF interested in medical education, clinical informatics, and primary care.
Learning Objectives

1. **Recognize the experience of learners** navigating the modified telemedical clinical training environment.

1. **Implement steps to incorporate learners** into this telemedicine environment **right now**.

1. **Describe 4 quadrants of clinical training in telemedicine** and use this framework to guide **future curricular design**.
Telemedicine is here to stay. You’ve been working hard to incorporate learners, but it’s been challenging...
The new clinical learning experience

New tools (e.g. Zoom) → Manage cognitive load to optimize learning

Virtual learning environment → New skills for instructors AND learners

Working/learning from home → Inequities that arise require flexibility, creativity, empathy

No in-person clinical encounters
- Loss of physical community, supervision
- Limited physical exam, no patient touch

...and more

Bad vs. Different?
So, what can I do *right now* for my learners who need to get back to clinical training?
A few suggested steps

1. Define what clinical experiences are available as Learner-supported vs. Learner-led

1. Revise existing objectives to align with these experiences.

1. Share clear, realistic expectations with your trainees and engage them in the process

1. Long term: Re-define what is possible.
Defining the Telemedicine Clinical Experience

**Learner-SUPPORTED**

- Appointments in Faculty’s “virtual office”
- Shadowing → Direct Observation
- Faculty/Staff carry logistic burden of getting patients into encounter
- Easy availability, no additional set-up
- Lower levels of learning (observer/reporter)

**Learner-LED**

- Appointments in Learner’s “virtual office”
- Direct Observation → Independent Practice
- Learner carries logistic burden of getting patient to visit, debugging
- More logistically challenging
- High levels of learning (interpreter/manager)
Your learners are back in virtual clinic. Now, your job is to make it “better”...what do you do?
4 Quadrants of Telehealth Training
Four levers you can pull to improve the *telemedicine clinical experience* for your trainees

- **OPTIMIZE LOGISTICS**
- **FACILITATE LEARNING**
- **BUILD SKILLS**
- **INNOVATE**
## 4 Quadrants of Telehealth Training

Four levers you can pull to improve the *telemedicine clinical experience* for your trainees

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OPTIMIZE LOGISTICS

Optimize Logistics to nurture a functional learning environment (reduce extraneous cognitive load)

• Guidelines for setting up the space at home
  • Provided needed technology if necessary?

• Tool specific logistics and training
  • Video platform (e.g. Zoom) access
  • Easy-to-reach tech support or pdf guides

• Transparent preceptor expectations
  • Clear schedules for virtual precepting
  • Establish a communication platform/backchannel (texting or private chat messages!)
  • Pre-clinic huddles

• Billing and note writing - Templates and coaching for learners
### 4 Quadrants of Telehealth Training

Four levers you can pull to improve the *telemedicine clinical experience* for your trainees

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BUILD SKILLS (in Tele-health)
Train learners in telemedicine clinical skills and how to deliver care via telemedicine

- **Teaching clinical assessment** via telemedicine
  - History taking, graceful interruption
  - Physical exam tips and techniques
  - Triaging and criteria for necessitating in-person visits
- **Panel management**
  - High risk patient identification + outreach
- **Managing patient messages** and "E-visits"
  - Even more important than before

What about just experiential/“On-the-fly” Learning?
- Easier for millennial learner (?tech-savvy) + inspires creativity and innovation.
- Risk of “Unknown unknowns” and inexperienced faculty
4 Quadrants of Telehealth Training

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FACILITATE LEARNING
Educate faculty and learners on unique learning environment and how to facilitate learning in a virtual setting

**Key Concept:** The virtual clinical learning environment is fundamentally different from the in-person environment. Faculty require new skills to teach effectively, learners require new strategies to learn effectively.

- **New challenges…**
  - Distractions/inequities, different visual and physical cues, loss in-person community, etc.

- **New opportunities!**
  - Easy to observe (learners or faculty)
  - Real-time backchannels for learning
  - Flexible educational conferences, distance isn’t a barrier

- **Known approaches for virtual learning**
  - Adapt strategies → see supplemental materials

Image: https://elearningindustry.com/now-time-create-effective-virtual-learning-experiences
### 4 Quadrants of Telehealth Training

Four levers you can pull to improve the *telemedicine clinical experience* for your trainees

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INNOVATE
Establish a mindset of innovation, remembering that telehealth is not bad, it is DIFFERENT!

• Your mindset is key to unlocking the potential of this platform
• Don't just recreate the in-person interaction in the telemedicine clinical experience
  • Remember the EHR?*
• Telehealth as an enhancement, not a replacement
  • Leverage the intrinsic strengths
• Engage the “end-user” = learners, instructors

*The modern EHR is, in many ways, simply a paper chart replicated in electronic form - it does not leverage the strengths of the digital platform. As a result, EHR usability has suffered and the potential of this tool has not yet been achieved.
4 Quadrants of Telehealth Training

Four levers you can pull to improve the *telemicine clinical experience* for your trainees

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“This framework is perfect to help {your name here} establish a positive clinical training experience in their program...

...in the era of telehealth.”

-Atul Gawande
(anticipated review) 😐
Recap

What can you do now?
1. Define what experiences are available
2. Revise existing objectives
3. Share clear, realistic expectations
4. Long term: Re-define what is possible

4 Quadrants of Telehealth Training
Four levers you can pull to improve the telemedicine clinical experience for your trainees
Thank you!

For more information: Supplemental Material
Faculty Development Considerations

Heather Billings, PhD, MA
Director, Faculty Development
Mayo Clinic College of Medicine and Science
Faculty Development Considerations

• Among physicians using telemedicine for consultation during the COVID-19 outbreak, nearly half (48%) are using it for the first time.
Faculty Development Considerations

- Among physicians using telemedicine for consultation during the COVID-19 outbreak, nearly half (48%) are using it for the first time.
Among physicians using telemedicine for consultation during the COVID-19 outbreak, nearly half (48%) are using it for the first time.
4 Stages of Competence – Learning Cycle

Don’t know that you don’t know

Know that you don’t know

Know what you know – with EFFORT

EFFORTLESS proficiency

Conscious Incompetence

Unconscious Incompetence

Conscious Competence

Unconscious Competence

Noel Burch, 1970
4 Stages of Competence – Learning Cycle

- **Unconscious Incompetence**: Don’t know that you don’t know
- **Conscious Incompetence**: Know that you don’t know
- **Unconscious Competence**: EFFORT
- **Conscious Competence**: EFFORTLESS proficiency
4 Stages of Competence – Learning Cycle

- **Unconscious Incompetence**
  - Don’t know that you don’t know

- **Conscious Incompetence**
  - Know that you don’t know

- **Conscious Competence**
  - Know what you know – with EFFORT
4 Stages of Competence – Learning Cycle

- **Unconscious Incompetence**: Don’t know that you don’t know
- **Conscious Incompetence**: Know that you don’t know
- **Conscious Competence**: Know what you know – with EFFORT
- **Unconscious Competence**: EFFORTLESS proficiency
Enthusiastic Beginner

Disillusioned Learner

Cautious Performer

Self-Reliant Achiever

*Hersey & Blanchard 1980s*
Aligning Objectives, Goals and Expectations

ACGME, 2012
Immediate Needs & Prioritized Topics

• Curriculum Design and Instructional Strategies – systems & technology

• Assessment Methods and Tools

• Clinical Skills, EHR Management, and Webside Manner

• Ethics, Patient Safety, Legal and Accreditation Requirements

• Provision and Solicitation of Feedback
Assessment & Feedback

- Timely
- Specific
- Observable
- Actionable
- Verbal – written – video – “nuances”
Faulty Development Models
I look forward to learning from all of you

Heather Billings, PhD, MA
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@MayoFacDev
Engaging Learners in Telemedicine Visits
Telehealth During the COVID-19 PHE
Privacy, Payment Policy and Documentation

Sherry L. Smith, MS, CPA
Director, Physician Payment Policy and Systems
American Medical Association
The AMA Encourages Appropriate Use of Telemedicine in the Education of Medical Students

Policy Adopted by the AMA House of Delegates:

- Our AMA encourages appropriate stakeholders to study the most effective methods for the instruction of medical students, residents, fellows and practicing physicians in the use of telemedicine and its capabilities and limitations. (CME Rep. 06, A-16)
- Our AMA will collaborate with appropriate stakeholders to reduce barriers to the incorporation of telemedicine into the education of physicians and other health care professionals. (CME Rep. 06, A-16)
Telemedicine, Privacy, and Security: HIPAA

- Generally, once outside data is incorporated into the patient’s electronic medical record, it becomes protected health information (PHI).
- Physicians are responsible for the privacy and security of PHI under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- The increased industry focus on digital health technology, including telemedicine, underscores the need for practices to consider how they will keep their patients’ PHI private and secure.
- HIPAA requires:
  - Business Associate Agreements (e.g., between a physician and the telemedicine platform vendor to ensure PHI is handled appropriately by the vendor)
  - Security Risk Analysis (a physician must evaluate how new technologies may expose PHI to inappropriate use or disclosure and take steps to address vulnerabilities)
  - Policies and procedures to help ensure proper confidentiality and security
Telemedicine: Privacy Best Practices

• We encourage physicians to notify patients of the potential privacy risks associated with use of telemedicine platforms and applications.

• Physicians should enable all available privacy and security tools available when using such applications.

• The AMA also encourages physicians to use platforms with end-to-end encryption.
  • Using an unencrypted audio-visual platform to communicate may result in third-parties being able to intercept the communications and “tap into” the conversation between a physician and patient.
Telemedicine: Vendor Privacy Considerations

• When selecting a telemedicine platform, it’s important to understand who has access to your patients’ data.

• Many practices don’t realize that a telemedicine platform or application may be low-cost or free because the vendor’s business model is based on aggregating and selling patients’ data.

• Physicians should review the vendor’s privacy practices, intended data use, and security protocols.
  
  ❑ Consult with your legal team and clarify how video, audio, and other data are being captured and stored by the vendor and who has access.
  
  ❑ Ensure the vendor is willing to sign a HIPAA Business Associate Agreement.
  
  ❑ Ask if the vendor will share results of third-party security audits, including SOC 2 or HITRUST, as well as results of penetration testing.
COVID-19 has ushered in the age of telemedicine—allowing physicians to take care of patients across the country

Remote and telehealth treatment has jumped, with over 90% of physicians now treating patients remotely.

Telemedicine tools are commonly used for remote treatment, with some 60% of coronavirus frontline healthcare workers and nearly all primary care physicians report using telehealth for at least some of their patient care.

Among physicians using telemedicine for consultation during the COVID-19 outbreak, nearly half (48%) are using it for the first time.

One-fifth of physicians using video conferencing and telemedicine tools expect to use them significantly more than before when we lift physical distancing restrictions.
Office for Civil Rights (OCR) – Enforcement Discretion Guidance

- HHS Office for Civil Rights (OCR) will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. Key regulatory requirements in play:
  - Security risk analysis on the telehealth technology platform
  - Business associate agreement (BAA) with permitted telehealth technology provider
- Telehealth services provided need not be directly related to the treatment or diagnosis of COVID-19
- Enforcement discretion extends through the COVID-19 pandemic, and OCR will issue a notice to the public when it is no longer exercising its enforcement discretion
OCR – Enforcement Discretion Guidance

- OCR’s guidance covers interactive communication technology (audio, text, messaging, or video)
  - Such as Facetime, Skype, or Zoom but NOT Facebook Live, Twitch, TikTok or other public facing communication services
- OCR notes that some vendors may be willing to enter into BAAs:
  - Skype for Business, Updox, VSee, Zoom for Healthcare, Doxy.me, and Google G Suite Hangouts
- Physicians are encouraged to notify patients of the potential privacy risks and should enable all available encryption and privacy modes when using such applications.
- The AMA also encourages physicians to use platforms with end-to-end encryption.
- Guidance is available here: [https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html](https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html)
The Role of the Telephone during the PHE

• Initial emergency declaration
  • Did not cover telephonic services, only two-way audiovisual
• Interim-final rule #1:
  • Allowed coverage of telephonic codes using existing codes (CPT codes 99441-99443)
  • But these codes had a lower payment rate than E/M codes
• Feedback from physicians prompted the AMA to call for greater flexibility and coverage for telephone calls
• Interim-final rule #2:
  • Allowed coverage of the telephonic codes with payment parity to Office Visits (99212-99214)
Supervision Allowances During PHE

• Levels of supervision
  • Personal
    • In the room
  • Direct
    • In the building
  • General
    • Available by phone

Direct supervision may be provided virtually using real-time audio/video technology
Medicare Beneficiary Telemedicine Consent

• Should not interfere with the service
• May be obtained at the same time, not necessarily before, the service
• Must be obtained at least once per year.

In comments on the Interim Final Rule, the AMA asked that CMS provide advice on when and how physicians must inform the patient that direct supervision by interactive telecommunication technology is being used.
CMS COVERAGE EXPANSION

E/M and Medicine Codes

CMS COVID-19 Interim Final Rules have significantly expanded the list of services which may be performed via telehealth.

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<td>262</td>
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Number of telemedicine – eligible codes in 2020 CPT® Professional Appendix P (CPT Codes That May Be Used for Synchronous Telemedicine Services) or on CMS list of Approved Telehealth codes

KEY EXPANSION THEMES

- Patient eligibility (New vs. Established)
- Face-to-Face
- Technology Requirements
Coding and Payment of Telemedicine during PHE

Telephone Evaluation and Management

CMS changed the status of telephone evaluation and management services from non-covered to active. Use for new or established patients. Codes are considered telehealth; exception to permit reporting with audio-only technology

- **99441** Phone E/M Physician/QHP; 5-10 minutes
- **99442** 11-20 minutes
- **99443** 21-30 minutes
- **98966** Healthcare Professional Phone Call; 5-10 min.
- **98967** 11-20 minutes
- **98968** 21-30 minutes

Payments for telephone visits have been adjusted for CPT codes 99441 – 99443 to be similar to CPT codes 99212 – 99214 during the public health emergency.
Coding and Payment of Telemedicine during PHE

Office and Other Outpatient Services (CPT codes 99201-99205, 99212-99215) Code Selection and Documentation – Telehealth Only

Physicians may select code and document based on medical decision making (MDM) or physician time on date of encounter:

- MDM – 2020 definitions
- Time – CPT® Typical Time

E/M 2021 selection methodology
Documentation in the Medical Record

The same level of documentation that would ordinarily be provided if the services furnished via telehealth were instead conducted in person.

Documentation Standards – Effective March 2018

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision-making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.
CPT® Special Coding Guides During COVID-19 PHE

• Provides real-world coding scenarios
• Combine with latest guidance from CMS, ICD-10-CM
• Incorporate special conditions/waiver effects
• Latest update: May 4

EXAMPLE

Scenario 9 – (COVID-19 or Non-COVID-19 case): Telehealth/Telephone visits

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<td><strong>Action</strong></td>
<td><strong>Patient evaluated via: E/M Telehealth, Telephone Visit</strong></td>
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<tr>
<td>Who is performing</td>
<td>Physician / QHP</td>
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<tr>
<td>Applicable CPT Code(s)</td>
<td>E/M Telehealth</td>
<td>Telephone Visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>New and Established Patients</td>
</tr>
<tr>
<td><strong>New Patient (CPT Times)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>99201 (typical time 10 min)</td>
<td></td>
<td>99441 (5-10 min)</td>
</tr>
<tr>
<td>99202 (typical time 20 min)</td>
<td></td>
<td>99442 (11-20 min)</td>
</tr>
<tr>
<td>99203 (typical time 30 min)</td>
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<tr>
<td>99204 (typical time 45 min)</td>
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<tr>
<td>99205 (typical time 60 min)</td>
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<td></td>
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<tr>
<td><strong>Established Patient (CPT Times)</strong></td>
<td></td>
<td>99443 (21-30 min)</td>
</tr>
<tr>
<td>99212 (typical time 10 min)</td>
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<td></td>
</tr>
<tr>
<td>99213 (typical time 15 min)</td>
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<tr>
<td>99214 (typical time 25 min)</td>
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<tr>
<td>99215 (typical time 40 min)</td>
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</tbody>
</table>

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<thead>
<tr>
<th>CPT® Codes</th>
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</thead>
</table>

| ICD-10-CM | | |


| Conditional Notes | | |

| Place of Service | 11 Physician Office or other applicable site of the practitioner’s normal office location | |

| Notes | | |

| | 1 CMS requires use of modifier 95 for telehealth services; other payors may require its use | |
| | 2 Individual states (through Executive Order) or payors may permit use of E/M codes with audio-only encounters. | |
| | 3 CMS will permit reporting of telehealth E/M office or other outpatient visits based on time or Medical Decision Making (MDM) | |
Telehealth Visits
Synchronous audio/visual visit between a patient and clinician for evaluation and management (E&M)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CPT Code 99201-99205</td>
<td>Office or other outpatient visit for the evaluation and management of a new patient</td>
</tr>
<tr>
<td>CPT Code 99211-99215</td>
<td>Office or other outpatient visit for the evaluation and management of an established patient</td>
</tr>
</tbody>
</table>

*Please note*—Check with your payer to determine the appropriate Place of Service (POS) code for your telehealth visits.

- [AMA Telehealth Playbook](#)
- [AMA Telehealth Quick Guide](#)
- [PIN Telehealth Amid COVID Virtual Panel Discussion](#)
- [The Telehealth Initiative](#)
  - AMA, Physicians Foundation, TMA, FMA, and MMS supporting physician practices with implementing telehealth services
- [AMA STEPS Forward Telehealth Module](#)
- [Summary of state directives to expand telemedicine services during COVID-19](#)
- [COVID-19 State Policy Guidance on Telemedicine](#)
AMA Innovations in Medical Education Webinar Series
Engaging learners in telemedicine visits: workflows to support teaching, feedback and billing

Questions
CONTINUING RESOURCES

Please join us to ask questions of our panelists at: https://ama-assn.org/communities/accelerating-change-in-medical-education