Updates in Telemedicine

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Objectives

- History of telehealth
- Types of telehealth
- Recognize the benefits and limitations of telehealth.
- Be aware of how telehealth can improve access to care as well as how it may discriminate against certain populations.
- Be comfortable with the logistics of performing a telehealth encounter.
- Be able to do a video physical exam.
- Know the common complaints that can be treated by telehealth
- 2025 Telehealth codes discussion

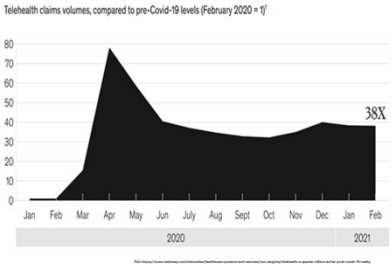
Pandemic gave a huge boost

- The World Health Organization defines telemedicine as the delivery of health services at a distance using electronic means for diagnosis, treatment, and prevention of disease
- Due to the rapid expansion of telehealth during the COVID public health emergency, telehealth services have been reimbursed by many insurance carriers.
- This expanded revenue stream helped support the telehealth services
- Even though quarantine and isolation periods are over, telehealth has shown power that it will stay

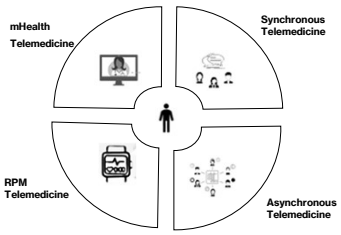
Effect of COVID-19

Rapid shift from in-person to telehealth.

- Reduced transmission
- Conservation of PPE



Types of Telemedicine



Remote Patient Monitoring

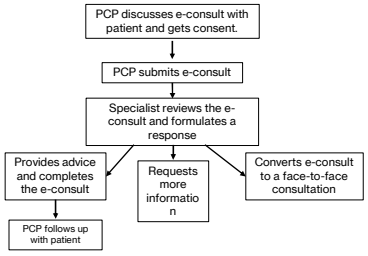
Condition	Monitor
Diabetes mellitus	Blood glucose/ pharmacist involvement
HTN management	BP and medication adjustment
Cardiac failure	Weight, Pulse oximetry, BP
Obesity	Weight management
Lung disease	Pulse oximetry
Behavioral health and substance abuse	Medication adherence, symptom surveys
Anticoagulation	INR
Geriatrics	Medical alert device, pill dispenser

Electronic Consultations (e-consult)

Goal: To improve access to specialty care without need for face-to-face visit

2024 Systematic Review Outcomes showed

most common reasons for implementing digital interdisciplinary e-consultation between FPs and hospital specialists were improving access to care and avoiding unnecessary referrals toward the hospital.



Then

- Acute conditions
- Asynchronous
- Text or Audio only
- Hospital/Clinic based
- Little to no reimbursement

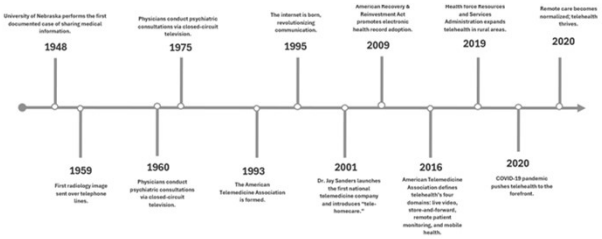
Evolution over time

Now

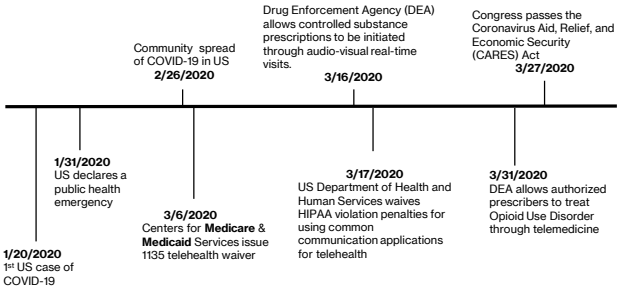
- Chronic care
- Synchronous
- Audio and video
- Home-based care
- Remote monitoring
- Increased Reimbursement

- **500 BCE**: Ancient Romans and Greeks use fire signals during plague outbreaks.
- **1948**: University of Nebraska performs the first documented case of sharing medical information.
- **1959**: First radiology image sent over telephone lines.
- **1960**: Physicians conduct psychiatric consultations via closed-circuit television.
- **1970**: Dr. Rashid organizes the first two national telemedicine conferences.
- **1975**: NASA transmits health data from animal tests back to Earth.
- **1989**: Indian Health Services and NASA send ECG and vital signs via microwave to a public hospital.
- **1995**: The internet is born, revolutionizing communication.
- **2001**: Dr. Jay Sanders launches the first national telemedicine company and introduces "tele-homecare."
- **2009**: American Recovery & Reinvestment Act promotes electronic health record adoption.
- **2016**: American Telemedicine Association defines telehealth's four domains: live video, store-and-forward, remote patient monitoring, and mobile health.
- **2019**: Health force Resources and Services Administration expands telehealth in rural areas.
- **2020**: COVID-19 pandemic pushes telehealth to the forefront.
- **2021**: Remote care becomes normalized; telehealth thrives.

Timeline of Telehealth



Events in 2020



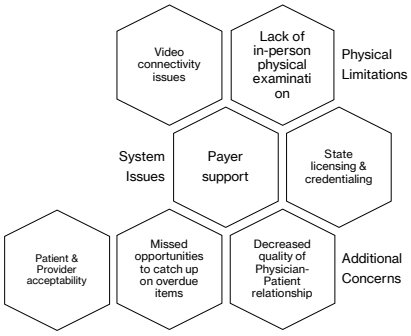
Benefits

"Traditionally telehealth has been viewed as a tool to improve access to services, but interest is growing to see if telehealth has the potential to reduce health care costs."

- U.S. Senate Committee on Finance

Increase access to care	Cost	Convenience
• Remote locations • Homebound individuals • Helps address transportation concerns • "maldistribution" of physicians	• Prevent ED visit • Lower rate of diagnostic testing • Decreased overall cost in a system • May increase use (# of visits).	• Saves time, travel, time off, childcare, etc. • High levels of patient satisfaction

Limitations



Clinic- Telehealth Model Example

Guiding principle	Description
Virtual visit structure	Built in template with visit types. 20 or 30-minute appointments for 10 slots
Location of provider/staff	• Dedicated space for Provider in home/ office. • Dedicated space for RNs in home/ office • Communication through electronic instant messaging
Consent for Tele visit	Phone room staff
Patient location	Home/ Any convenient location within Ohio/ Patients advised about the virtual nature of the visits
Preferred platform	Integrated health record video portal
Clinical engagement	Through on-going training/ Clinical Resources page/ Quarterly meetings

Telehealth rules for physicians in Ohio

- **Standard of care:**
- The standard of care for a telehealth visit is the same as for an in-person visit. The technology used must be able to meet this standard, or the provider must conduct an in-person visit or make a referral.
- **Patient identification and consent:**
- You must verify the patient's identity and physical location, and document their informed consent for treatment.
- **Privacy and security:**
- All telehealth services must adhere to federal and state privacy and security standards.
- **Medical evaluation and record-keeping:**
- You must conduct a complete and documented medical evaluation, diagnosis, and treatment plan. You must also make the patient's medical records available to them or their guardian.
- **Prescribing controlled substances:**
- For a new patient, a physical examination is required before prescribing a Schedule II controlled substance, unless an exception applies.
- Exceptions to the in-person exam for new patients include hospice or palliative care, substance use disorder treatment, mental health treatment, or emergency situations.
- **Remote monitoring:**
- You may use FDA-cleared or approved remote monitoring devices if the patient gives consent and the devices comply with all federal requirements.
- **Patient location:**
- These rules apply to telehealth services provided to patients located in Ohio. You must also follow the laws of the state where the patient is located if they are outside of Ohio.

Common symptoms appropriate for a telehealth clinic

- URI- Sinus Congestion/Pharyngitis/Laryngitis/Bronchitis/Viral/Bacterial
- Paxlovid prescriptions
- Allergies- Rhinitis, itchy eyes
- Conjunctivitis/Pink eye/ Simple stye
- Thrush
- Skin complaints- Rash/Bruise/Dermatitis/Folliculitis
- UTI
- High BP
- High Sugar
- Discussion of lab results
- Anxiety/Depression that needs meds/counseling
- Simple MSK pain/ Minor sprain
- Simple Insomnia
- Hospital follow up

Common symptoms that are difficult to do via telehealth

- Chest pain
- Vertigo
- Dyspnea
- Abdominal pain
- Complaint of a mass
- Very young children who are nonverbal
- Patients who are nonverbal for other reasons, such as intellectual disability

Pre-rooming steps

- I contacted patient on 10/15/2025 12:53 PM. Answers were put into visit during pre-charting.
- Will the patient be in the state of Ohio at the time of the telehealth visit? Yes
- **If no, notify your manager & clinical manager of potential issue
- Chief complaint entered and any additional discussion items added to chief complaint comments. Yes
- Confirm mode for the visit is MyChart Video visit: MyChart
- MyChart - confirm patients knows to login 15 min in advance. Yes
- I entered/confirmed pharmacy and updated on chart. Yes
- I reviewed allergies and marked reviewed on chart: Yes
- I reviewed tobacco use and updated on chart: Yes
- I reviewed medications and asked patient to have them available at time of visit. Additional medications not in med list added to list. Medications patient no longer taking removed from list. Yes
- Any refills needed (if yes, please queue up)? No
- Informed patient that if they do not receive link for their video visit within 15 minutes of scheduled appointment time, to contact that office directly to see if clinic is running late? Yes
- I asked for any home vitals listed in the visit notes such as weight, blood pressure, etc. and entered them into vitals. If patient is on Oxygen, I documented their most recent oxygen level in the SpO2 field. Yes

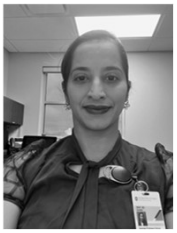
- The rooming can be performed by the MA or phone room
- Would be good time to set up expectations about the appointment

Clinic set up

- Good professional set up is important as it shows your commitment to make this helpful for patients

Dress professionally

- Wear your name badge so patients can see your name



Preparing the patient for the visit

- Pre-rooming from phone room or MA
- Location – A quiet room in home or office/ Emphasize no driving!!
- Set expectations that provider may run late and what to do if the connection is not successful
- Test connection if possible
- Ask them to be ready with the necessary data for the visit like medications that they take, test results like covid or flu test etc.

Documentation required for telehealth

History taking

- TAKING HISTORY IS VERY IMPORTANT
- You can still get a good amount of information with some creativity
- You can involve the patient, care givers, and other technology

Examination

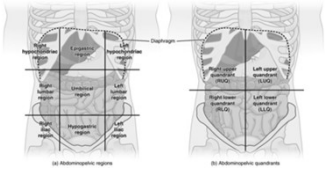
- Observe the patient
- Watch for speech/level of alertness/cognition
- Work of breathing and SOB
- Vital signs – If possible, ask them to hold up the measurements to the camera

Cardiac and Lung exam

- Pulse (rate and regularity)
- Deeply inhale/exhale with the mouth open
- Audible wheezing
- O2 sat
- May get additional data from home monitors and wearables
- Edema
- This is a really a screen to decide who needs to be seen in person and/or who needs imaging

Abdominal exam

- Patient assisted
- Inspection
- Palpation



Neurologic exam

- Alert, oriented
- Speech
- Basic cranial nerve exam (EOM, Facial and hypoglossal nerve)
- Basic Motor exam
- Gait
- Motor exam

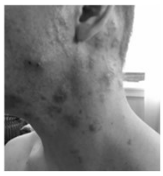
MSK exam



Ref: https://pmc.ncbi.nlm.nih.gov/articles/PMC7395661/

Skin exam

- Many platforms allow you to take still shots during the video feed
- Ask the patient to take pictures of the rash/ lesion and send a picture file via a secure patient portal
- It is helpful to coach the patient on optimal skin photos
  - Lighting
  - A close-up shot
  - Include an anatomical landmark



2025 Telehealth E and M codes

Synchronous Video Evaluation and Management Services					
New Video			Est. Video		
Code	MDM	Time	Code	MDM	Time
98000	S/F	15	98004	S/F	10
98001	Low	30	98005	Low	20
98002	Mod	45	98006	Mod	30
98003	High	60	98007	High	40

Synchronous Audio-Only Evaluation and Management Services					
New Audio-Only			Est. Audio-Only		
Code	MDM	Time	Code	MDM	Time
98008	S/F	15	98012	S/F	>10
98009	Low	30	98013	Low	20
98010	Mod	45	98014	Mod	30
98011	High	60	98015	High	40

90791 Psychiatric Diagnostic Evaluation
90832 Psychotherapy 30 min. (16-37 min.)
90834 Psychotherapy 45 min. (38-52 min.)
90837 Psychotherapy 60 min. (53 min. or more)

Telehealth codes continued..

Virtual Check-In (Patient Initiated) The service is **patient-initiated** and intended to evaluate whether a more extensive visit type is required			
Code	**Time**	**Patient Type**	**Who can report?**
98016	5-10 minutes	Established Patient	A physician or other qualified health care professional who can report E/M services
Exception: For services of 5 to 10 minutes of medical discussion, report 98016, if appropriate from a **scheduled** audio only visit.			

The Do Not's of Telemedicine Services
Telemedicine services should not be reported for routine communication related to a previous encounter(example: to communicate laboratory results) or when clinical staff are responsible for communicating back to the patient.
Services of less than five minutes are not reported; encounter should be NCNC
Audio- only: Must be more than 10 minutes of medical discussion

E- visit E/M

- E-visits are utilized for responding to **patient- initiated health concerns** and medical questions through a patient portal.
- Providers can utilize (E/M) services if making a clinical decision that typically would have been provided in the office (example : adjustment of existing medicines, ordering a test, or prescribe a new medicine)

Telehealth e-visit codes

eVisit (MyChart) Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.

Code	Time	Patient Type	Who can report?
99421	5-10 minutes	Established Patient	Physician and APP's
99422	11-20 minutes	Established Patient	
99423	21 or more minutes	Established Patient	

eVisit (MyChart) Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days.

Code	Time	Patient Type	Who can report?
98970	5-10 minutes	Established Patient	Non-physician (e.g., registered dieticians, physical therapists, occupational therapists, and speech-language pathologists):
98971	11-20 minutes	Established Patient	
98972	21 or more minutes	Established Patient	

The Do Not's of e-Visit Services

- Service of less than five minutes are not reported; encounter should be NCNC
- When a provider is simply disseminating test results, processing requests for medicines, or scheduling an appointment/ placing a referral (an E/M service must be performed to bill)
- The patient inquiry is related to a surgical procedure and occurs within the post- op period of the procedure
- Within the 7-day period for the same or similar condition of the E-visit when a separate face-to-face encounter E/M service (in-person or telehealth) occurs as this will be considered included in the E/M
- Do not report 99421, 99422, 99423 for home and outpatient INR monitoring when reporting 93792, 99793
- An E-visit for this patient was billed within the past 7 days for the same or similar condition.

"This study is really important for providing Congress with the evidence that they need to support the concept of extending waivers."
Lee Schwamm, MD

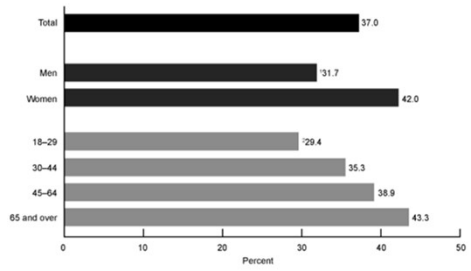
- One of the largest randomized clinical trials to directly compare telehealth and in-person care has found that they are equally effective in improving quality of life in patients seeking palliative care – specialized care focused on managing the symptoms of serious illness.
- The use of telehealth surged at the height of the COVID-19 pandemic through waivers that expanded Medicare coverage for a wide range of medical services. These flexibilities are set to expire by the end of 2024 unless Congress takes action to extend them – and many private insurers follow Medicare's lead. While advocates argue that telehealth improves accessibility, policymakers have expressed concerns about quality of care, costs, and the potential for fraud.
- Palliative care

Data about telehealth

Data from the National Health Interview Survey	In 2021, 37.0% of adults used telemedicine in the past 12 months.	Telemedicine use increased with age and was higher among women (42.0%) compared with men (31.7%).
Non-Hispanic White (39.2%) and non-Hispanic American Indian or Alaska Native (40.6%) adults were more likely to use telemedicine compared with Hispanic (32.8%), non-Hispanic Black (33.1%), and non-Hispanic Asian (33.0%) adults.	The percentage of adults who used telemedicine increased with education level and varied by family income.	The percentage of adults who used telemedicine varied by region and decreased with decreasing urbanization level.

Data

- Percentage of adults aged 18 and over who used telemedicine in the past 12 months, by sex and age: United States, 2021



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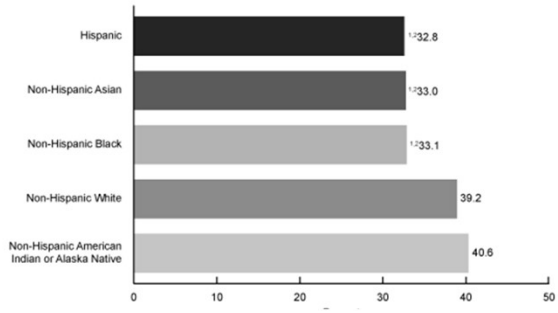

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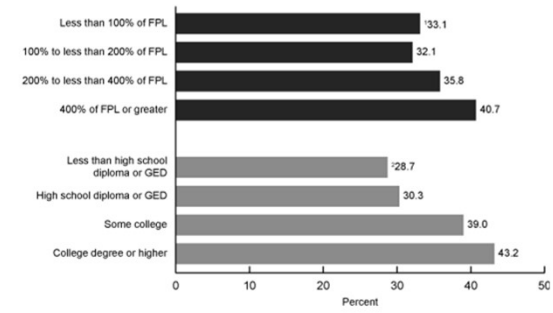

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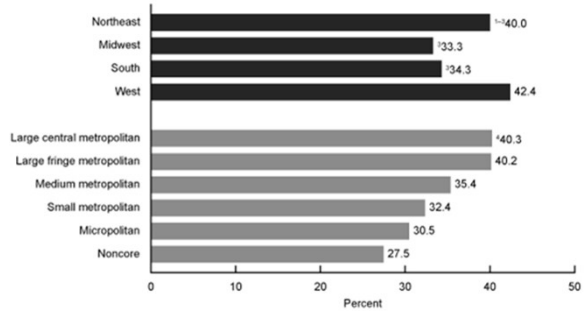

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Timeline of events since 2023

Year/Date	Event
2020	Congress first implemented Medicare telehealth flexibilities during the COVID-19 Public Health Emergency (PHE). (CARES act)
2021	2021 Consolidated Appropriations Act (CAA) extended or made permanent some telehealth flexibilities.
2022	2022 CAA further extended telehealth provisions.
2023	2023 CAA continued extensions.
Dec 2024	Draft spending bill proposed a two-year extension (later scrapped before the Dec 20 shutdown).
Mar 31, 2025	Extensions continued through the 2025 American Relief Act.
Sep 30, 2025	Extensions continued again through the 2025 Full-Year Continuing Appropriations and Extensions Act.

Congress action

Telehealth Modernization Act (H.R. 5081 / S. 2709)

Introduced September 2, 2025, by Rep. Buddy Carter (R-GA) and Rep. Debbie Dingell (D-MI) and September 4, 2025, by Sen. Tim Scott (R-SC), Sen. Brian Schatz (D-HI), Sen. Cindy Hyde-Smith (R-MS), Sen. Kirsten Gillibrand (D-NY), Sen. Thom Tillis (R-NC), and Sen. Angus King (I-ME)

The bill would extend the Medicare telehealth flexibilities through September 30, 2027.

CONNECT for Health Act of 2025 (S. 1261 / H.R. 4206)

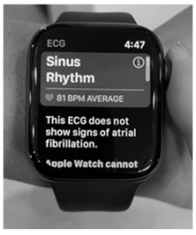
Reintroduced April 2, 2025, by Sen. Brian Schatz (D-HI) and 60 other Senators, and June 26, 2025, by Rep. Mike Thompson (D-CA), Rep. David Schweikert (R-AZ), Rep. Doris Matsui (D-CA), and Rep. Troy Balderson (R-OH)

This comprehensive bipartisan bill would make the Medicare telehealth flexibilities permanent.

Flexibility	Current (through 9/30/25)	After Expiration (10/1/25)
Originating Site	Any U.S. location, including the patient's home	Limited to certain locations, e.g., Provider's office, Hospital, Skilled nursing facility, ESRD home dialysis, SUD or co-occurring mental health disorder, Mental health disorder home (if in-person requirement met)
Geographic Restrictions	No geographic restrictions	Patients must be located in a rural health professional shortage area or non-Metropolitan Statistical Area, except for ESRD, acute stroke, SUD, or mental health disorder cases (if in-person requirement met)
Audio-Only Visits	Available for any telehealth service, if clinically appropriate	Limited to patients at home if provider can use video but patient cannot or will not
Expanded Provider Types	Any Medicare-eligible provider (e.g., therapists, pathologists, audiologists, etc.)	Limited to Physicians, PAs, NPs, CNSs, Nurse-midwives, Clinical psychologists/social workers, Dietitians, CRNAs, Marriage/family therapists, Mental health counselors
FQHC/RHC as Distant Site	FQHCs and RHCs are eligible distant sites	FQHCs and RHCs are not eligible distant sites
Mental Health In-Person Visit	No in-person visit requirement	Required within 6 months prior to initial telehealth visit and every 12 months thereafter, unless documented exception. FQHC/RHC requirements resume Jan 1, 2026.

Future Directions

- Building it into practice
  - Considering telehealth needs when building new clinics
- Integrating telehealth in medical schools and residencies
- Standardized competencies
- Expand reimbursement beyond state of emergency
  - Increase coverage for electronic visits, telephone visits, remote monitoring
- Expanding care in developing nations/ Collaborate with physicians there
- Technological advances
  - Smartphones, wearable devices
  - Improved sensors
  - At home testing



Resources for Providers

- Department of Health and Human Services: https://telehealth.hhs.gov/
- Rural Health Information Hub: https://www.ruralhealthinfo.org/topics/telehealth
  - FAQ, toolkit, links to local resources
- Center for Connected Health Policy: https://www.cchpca.org/
  - Interactive map with current state laws and reimbursement
- Federation of State Medical Boards: https://www.fsmb.org/advocacy/covid-19/
  - State licensing regulations and waivers