Telehealth – Connecting Patients and Providers During the COVID-19 Pandemic Crisis

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Introduction

The COVID-19 pandemic has triggered a seismic shift across the globe, affecting countless areas of life. This pandemic has crippled the global economy, shut down essential day-to-day activities like schools, hospitals, businesses, and confined individuals to their homes for extended periods.[1,2] Subsequently, the health of individuals has been severely curtailed given limited access to healthcare services. Many hospitals had to divert their resources to managing COVID -19 patients leaving rationed care for non-COVID-19 patients.[2] As a result, numerous patients had to adapt to connecting virtually with their healthcare providers. As social distancing mandates extend, communication using digital technology or telehealth has become a necessity, and a primary and efficient mode of communication between patients and healthcare providers.[3,4]

Telehealth, broadly defined, is digital technology-enabled medical care and health education services. The federal Health Resources and Services Administration (HRSA) defines telehealth as *"the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration".*[5]

Although at times telehealth is used synonymously with telemedicine, telemedicine is more often used for physician care and is defined as "*the use of electronic technology or media, including interactive video conferencing technologies, for the purpose of diagnosing or treating a patient, providing remote patient monitoring services, or consulting with other health care providers regarding a patient's diagnosis or treatment*".[4]

Telehealth enables healthcare professionals to assess, diagnose, and treat patients in remote locations with the use of telecommunications, video conferencing, and digital image technologies. Through telehealth, patients can connect to their healthcare providers expeditiously and privately without the need for travel, particularly during the COVID-19 pandemic. It offers the opportunity to deliver medical care for underserved populations and for those with limited access to medical services, thus overcoming barriers of distance and time.

Telehealth not only can save time and effort for patients but also may improve patient clinical outcomes. A study comparing telemedicine and telephone only consults for stroke patients demonstrated that the telemedicine consults resulted in a more accurate medical decision-making process compared to telephone only consultations.[6] A case-control observational study compared virtual consultations to traditional consultations among patients and found that there were no differences in the information given by the medical providers and patient satisfaction between the two types of consults.[7] A systematic review of 20 studies by Shigekawa, et al (2018) showed that telehealth care is generally equivalent to face-to-face interventions.[8] Several additional studies have demonstrated the potential use of telehealth in medical management without compromising the cost or quality of care.[9-11]

Telehealth use during COVID_19

The emergence of the COVID-19 crisis has expanded the application of telehealth extensively. Telehealth services facilitate COVID-19 mitigation approaches by avoiding social contact in order to reduce the spread of the infection. For example, the Virginia Commonwealth University Hospital System (VCUHS) shifted its ambulatory and low acuity patient care from face to face consults to telehealth consults. Within weeks of this change, their volume of telehealth consults increased from an average of 30 to 1700 consults per day, an increase of more than

5000%.[4] Similar increases in virtual consults have also been reported by other studies.[12,13] A shift to telehealth decreases the burden on healthcare systems by minimizing the demand for hospital beds, staffing, and space at facilities.[4] It also reduces the need for personal protective equipment (PPE) used by healthcare providers, which already is in short supply. These measures aid in decreasing the cost of care to the healthcare system.

In addition, minimizing contact between patients and healthcare providers via telehealth systems decreases the risk of healthcare professionals contracting COVID-19.[2,4] This is significant as the healthcare workforce has already been reduced due to hospital closures and canceled elective surgeries. Any further reduction in staffing will severely affect the healthcare labor pool. Additionally, staffing challenges continue as some healthcare professionals inadvertently are exposed to patients with COVID-19 requiring mandatory self-quarantine.[4]

The COVID-19 pandemic has compelled providers to rethink the delivery of healthcare. Effectively utilizing telehealth for the provision of healthcare may soon be a mainstream method to diagnose and treat patients. Understanding and optimizing this model of healthcare will likely become imperative well beyond this current global public health crisis.

Telehealth Regulatory Standards

In 2011, the Centers for Medicare and Medicaid Services (CMS) issued the final rule to make federal requirements more flexible for rural, small hospitals and for critical access hospitals to provide care via telemedicine. This rule in part encouraged innovative approaches to patient-service delivery for which CMS set the standard. With this rule, Medicare reimburses for specific telehealth services when the originating site (location of the patient) is in a Health Professional Shortage Area (HPSA) or in a county that is outside of any Metropolitan Statistical Area (MSA) as defined by the Health Resources and Service Administration (HRSA) and the Census Bureau. Medicaid programs' reimbursement standards vary from state to state and include what services are covered and which providers can bill.[19,20]

Regulatory agencies have additional telehealth standards. The Joint Commission (TJC) and Healthcare Facilities Accreditation Program (HFAP) survey hospitals for the provision of services according to CMS regulations. The TJC standard for the provision of telemedicine services (Medical Staff Standard-MS.13.01.03) is based on recommendations by the medical staff. The standard includes a requirement that the originating site needs to evaluate the ability to provide telemedicine according to regulations. The distant site evaluates performance and quality of services provided. The elements of performance include which clinical services provide telehealth, and if the clinical services are consistent with quality standards. HFAP standards require Telemedicine Privileging Provisions through Distant-Site Hospital Agreement- 03.00.07 and Telemedicine Privileging Provisions through Distant-Site Telemedicine Entity Agreement – 03.00.08.[20] If telehealth services are being provided by a hospital-based program, then it is advised to check with the hospital's medical staff office if services meet the standards set.

Telenutrition

Telenutrition can help improve patient outcomes and remove barriers of access to care, which include time, distance to travel for appointments, and provider scarcities.[14-19] It involves the interactive use of electronic information and telecommunications technologies, by an RDN, to implement the Nutrition Care Process with patients or clients at a remote location, within the provisions of their state licensure as applicable. Licensure requirements vary from state to state.[19] The website https://www.telehealthpolicy.us/telehealth-policy/current-state-laws-and-reimbursement-policies# gives the current information for each state.

Billing Codes for Telenutrition

There are a variety of Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes and modifiers used to track and reimburse for telenutrition services. CPT codes describe the procedure or service being delivered by the healthcare provider. HCPCS is a set of codes, including G codes, which further identify professional healthcare services beyond the CPT codes. These

codes are used by CMS and are also widely recognized by private payers. Medicare Part B will reimburse for Medical Nutrition Therapy (MNT) for diagnoses of diabetes or chronic kidney disease only. Other payers will vary in the covered diagnoses covered for MNT; individual payer policies need to be checked for specific coverage parameters. [21]

CPT and HCPCS Codes for MNT*

- 97802: Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
- 97803: Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes.
- 97804: Group [2 or more individuals], each 30 minutes.

MNT can only be billed for time spent face-to-face with the patient, and cannot include coordination of care, documentation time, etc. MNT is limited to three hours the first year, and two hours per year thereafter. The following G code may be used if additional MNT hours are needed for a change in diagnosis, medical condition, or treatment regimen.

- G0270: Medical Nutrition Therapy; reassessment and subsequent intervention(s) following second referral in same year, individual, face-to-face with the patient, each 15 minutes.

Additional CPT Education & Training Codes*

These codes may be recognized by private payers. They are typically not reimbursed by Medicare Part B but have been temporarily permitted during the national COVID-19 health emergency. These codes may be used for telephone assessment and management services provided by a qualified non-physician healthcare professional to an established patient, parent, or guardian. These can be used if the encounter is greater than seven days following an MNT visit. For example, these could be used when a patient calls two weeks after their initial MNT appointment with a question about a new food product, how to manage new lab results, etc. One important point to note is that these encounters are required to be patient initiated.

- 98966: 5 to 10 minutes
- 98967: 11 to 20 minutes
- 98968: 21 to 30 minutes

The following CPT codes are not reimbursed by Medicare Part B but may be reimbursed by private payers. These codes are used for online assessment and management service provided by a qualified non-physician healthcare professional to an established patient, for up to seven days, cumulative time in the seven days, for electronic communication. Examples would be encounters or questions initiated via an online digital platform, email, or patient healthcare portal.[21] Again, these encounters need to be patient initiated.

- 98970: 5-10 minutes
- 98971: 11-20 minutes
- 98972: 21 or more minutes

Other Services

DSMT (Diabetes Self-Management and Training) services (G0108* and G0109*) and Incident-to services, such as Intensive Behavioral Therapy for Obesity (G0447*) may be provided via telehealth during the COVID-19 national health emergency.

Codes Specific to Telehealth*

The specific code for telehealth is Place of Service Code (POS) 02. During the COVID-19 public health emergency, the place of service code can continue to be the same as if it were in-person. Also because of the pandemic, the Medicare rules for telehealth have been temporarily relaxed so that the patient and/or the provider can be at home.[21] Other modifiers that describe how the service is provided and that must be included in the billing process include:

- 95: Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications system. Modifier 95 should be applied to claims that describe services provided via telehealth, regardless if services were provided using approved audio-visual technology or using audio-only communication (telephone).[21]
- GQ: Asynchronous Telecommunications systems, such as a pre-recorded video[21]
- GT: Interactive Audio and Video Telecommunications systems, including a live video conferencing session[21]

Documentation in the patient's medical record should include how the service was provided, i.e. au-

dio only or audio and video. Under normal circumstances, CMS specifies that telehealth services need to contain both live audio and video components, but the regulations have been relaxed so that audio only is permitted during the national health emergency. Other payers may have different billing requirements for telehealth and their provider services should be contacted for clarification. Links to sample telehealth policies from major national payers are available on the Academy website's Telehealth Quick Guide for RDNs.[21]

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Equipment for Telehealth

Equipment for telehealth includes interactive, specialized equipment for health promotion, disease prevention, consultation, therapy and/or nutrition intervention/plan of care. It also includes non-interactive (passive) communications over the internet, video conferencing, e-mail or fax lines and other methods. Communications technology must be in compliance with payer requirements in order to provide MNT remotely. The platform used must be secure, non-public facing, and Health Insurance Portability and Accountability Act (HIPAA) compliant. In order to receive payment for services, audio-visual platforms must be used by both the provider and the patient and must be in real-time. If delivered on behalf of an organization, it is best to consult with the organization's legal counsel to determine if the platform used is meeting the guidelines.[19-21]

Due to COVID-19, some Medicare regulations have been relaxed regarding non-public facing communications technology as long as fraud is not being committed. However, not all states have relaxed these requirements and the length of time for the current enhanced allowances is undetermined. Therefore, it is recommended that the provider should be cautious and adhere to the strictest of the applicable requirements. There are vendors who provide HIPAA-compliant video communication technology that meet both Medicare and state guidelines. If using popular non-public facing applications that allow video chat, all conceivable precautions must be taken to enable encryption and privacy modes. Public-facing applications should not be used. When using private devices to communicate with patients, an application such as Doximity allows the user to securely contact patients while masking personal contact information.[21] See Table 1.

Considerations for the RDN

Reimbursement

- CMS will reimburse for MNT provided remotely for diabetes mellitus and non-dialysis kidney disease.[21]
- Private insurers may place limits on payment for MNT.[21]
- Medicaid reimbursement for MNT provided via telehealth will vary by state.[21]
- Not all telehealth is reimbursable. However, even if it's not reimbursed, provision of MNT can help prevent hospital readmissions, which can impact the organization's bottom line.[21]

Licensure

- Be familiar with licensure laws for the state where the RDN is located, and where the client/patient is located.[21]
- RDNs must be credentialed and privileged if the state does not have licensure laws for RDNs.[21]

HIPAA-Compliant Apps	Non-Public Facing Apps	Public-Facing Apps (Do Not Use)
Skype for Business	FaceTime	Facebook Live
Microsoft Teams	Messenger	Twitch
Zoom for Healthcare	Hangouts	Tik Tok
Doxy.me	Whatsapp	Slack
G Suite Hangouts Meet	Zoom	
Webex	Skype	
Updox		
VSee		
Chime		
GoToMeeting		
Spruce Health Care Messenger		

Table 1. Communications platforms

Logistics

- Determine processes for how to remotely:
  - Register a patient/client for an appointment
  - Obtain insurance information
  - Obtain consents for treatment via telehealth
  - Collect payments and issue receipts
  - Share information with patients/clients[21]
- Become familiar with the technology being used. For example, camera positioning on the device being used can make a difference in obtaining best results and practicing the use of technology can ensure good patient/client interactions.[21]

Conclusion

Telenutrition can provide cost-savings to a healthcare system since it is an efficient and cost-effective method of delivering a service.[16-19] RDNs should become involved with their organization's remote monitoring and education programs to see where the RDN can make a difference.

During the COVID-19 national public health emergency, Medicare and other payers have temporarily modified their policies and rules to expand access to care via telehealth including:

- Audio-only platforms are permitted to deliver MNT, DSMT, and IBT for Obesity
- CPT codes for telephone assessment and management (98966-98968) are being reimbursed
- Rules regarding communications technology have been relaxed.[21]

It is time to take advantage of the opportunities that have arisen to implement the technology to provide another avenue of service to our patients/clients. RDNs should stay current with any policy changes when the national public health emergency concludes.

Additional Telehealth Resources

- COVID-19 Professional Resource Hub/ Telehealth and Nutrition Services: https://www.eatrightpro.org/coronavirus-resources
- https://www.eatrightpro.org/practice/practice-resources/telehealth#quickGuide
- Practice Tips: Telehealth Challenges and Opportunities: https://www.eatrightpro.org/practice/practice-resources/telehealth/medicare-telehealth-services-and-registered-dietitians
- http://www.telehealthpolicy.us/state-laws-and-reimbursement-policies
- Telehealth Start-Up and Resource Guide: http://www.americantelemed.org/home

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MNT Via Telehealth During the COVID-19 Pandemic as Experienced by an Outpatient Nutrition Team

By Agnieszka Sowa, MS, RD, LD, CNSC, Katherine Patton, MEd, RD, LD, CSSD, and Lisa Burnett, MS, RD, LD

Telehealth is the provision of health services via electronic and telecommunication technologies. Studies have shown that telehealth enables health professionals to provide high quality care comparable to that provided via face-to-face visits.[1] Telehealth services have also been shown to improve access to care and reduce costs.[1,2] The recent emergence of the COVID-19 pandemic has dramatically influenced our practices for providing medical nutrition therapy (MNT) to our patients. More specifically, it has shifted our focus away from face-to-face visits to those provided via virtual and phone platforms. In this article we will discuss the changes our outpatient nutrition therapy team underwent during the COVID-19 pandemic and highlight the adjustments needed to provide care from a distance.

Pre-COVID Practice

The Center for Human Nutrition (CHN) is a part of the Digestive Disease and Surgery Institute at Cleveland Clinic. The CHN mission is to provide the highest quality care through leadership in practice, education and research. The CHN includes 130 employees who make up four nutrition teams. The four teams are Inpatient Nutrition Therapy, Outpatient Nutrition Therapy (ONT), Nutrition Support Team, and Center for Gut Rehab & Home Nutrition Support Team.[3]

Prior to COVID-19, the ONT team was off to a successful start to 2020. We were fully staffed with 14 full time registered dietitian nutritionists (RDNs), four part time RDNs, and one PRN RDN. This team provided MNT services to patients at 23 clinics throughout the enterprise, including the main campus and family health centers. Our care included: in-person one-on-one appointments, group appointments via shared medical appointments (SMA) and shared nutrition appointments (SNA), as well as virtual visits.

While the majority of our visits were provided face-to-face, virtual visits have been offered by the ONT team since 2016. However, prior to the pandemic, virtual visits were only available as a self-pay option, which may have affected patients' willingness to make such an appointment. Additionally, licensure laws allowed us to provide MNT via telehealth only to those living in Ohio and a few states without RD licensure, limiting our ability to provide care to patients who lived or traveled outside those states. In 2019, ONT completed a total of 51 virtual visits.

In an effort to increase the number of telehealth visits, one of our team goals for 2020 was to train and equip all the RDNs on our team to be able to provide virtual appointments. At the end of 2019, we had evaluated quantities of equipment needed and purchased it in the beginning of 2020. Equipment needed for virtual visits with desktop computers is a simple camera and a sound bar. Some offices were already equipped; nine additional sets of devices needed to be installed. Set up of this gear is very easy and does not require assistance of information technology (IT) personnel, therefore the RDNs on our team were able to do so independently.

Additionally, we made arrangements with our Distance Health Liaison to train our team in providing virtual visits and set up accounts for each RDN in our virtual platform. At the start of 2020, eight RDNs on our team already provided virtual visits and three additional RDNs were trained in preparation to begin offering virtual visits in their clinic. Training for the remainder of the team was completed by the end of March 2020. Training included the basics of logging into the program, connecting with the patient, and conducting and ending the visit.

COVID Related Changes to Practice

Transitioning to Remote Appointments

With the onset of the pandemic, individual face-to-

face appointments and limited numbers of virtual appointments were initially our only avenue of providing MNT to patients. All group appointments (SMAs and SNAs) were cancelled and patients were rescheduled to one-on-one appointments. Additionally, our Eat Well program (a ten-week weight management group developed by the ONT RDNs that supports our employee health program) was temporarily put on hold and later delivered via one-on-one appointments as well. Due to emerging worry and uncertainty we experienced a significant decline in the number of patients who kept their appointments. Our schedule fill rates decreased from 78% in the first two months of the year to about 62% in March. Our fill rates remained in the low sixties in April and May (see Table 1).

At the end of March, an enterprise-wide decision was made to allow all employees who are able to work remotely to do so. Following this decision, we made arrangements for the ONT team to work distantly. These arrangements included obtaining 17 laptops and headsets, Virtual Private Network (VPN) access, phone number connection and signing a remote work contract. While not without some technical difficulties, this was a welcome change as this increased caregiver and patient safety, and reduced unnecessary exposure to the virus.

Billing Changes

As the clinic and the world was learning more about COVID, the clinic recommended converting in-person appointments to virtual visits. Working with our Revenue Cycle Business Partner and Distance Health team, we updated our billing system from self-pay only to a system where all the charges are now submitted to the patients' insurance first. The Cleveland Clinic also waived all co-pays, payments and charges for any uncovered services during the initial months of the pandemic. While patients were still allowed to come in for in-person appointments, many switched to virtual visits or rescheduled their appointments for a future date.

Technology Challenges

The imposing number of virtual visits overwhelmed the virtual platform, causing many failures of these appointments. With the relaxation of Health Insurance Portability and Accountability Act (HIPAA) rules by the Centers for Medicare and Medicaid Services (CMS), our clinicians were allowed to perform such visits via FaceTime or Google Duo. Moreover, to help provide appropriate and timely care to our patients, the clinic approved the use of phone appointments, to be utilized especially in cases where the virtual visits failed, but also as an alternative for patients who did not have the technology necessary to participate in a virtual visit. When using their personal phones, some RDNs blinded their number. Others did not but informed patients that it was their personal number and should not be used for call backs, and then blocked the patients' numbers to prevent this. Furthermore, we were allowed to provide both phone and virtual appointments outside of Ohio to patients that were already established with the clinic, further increasing our reach. With all the changes

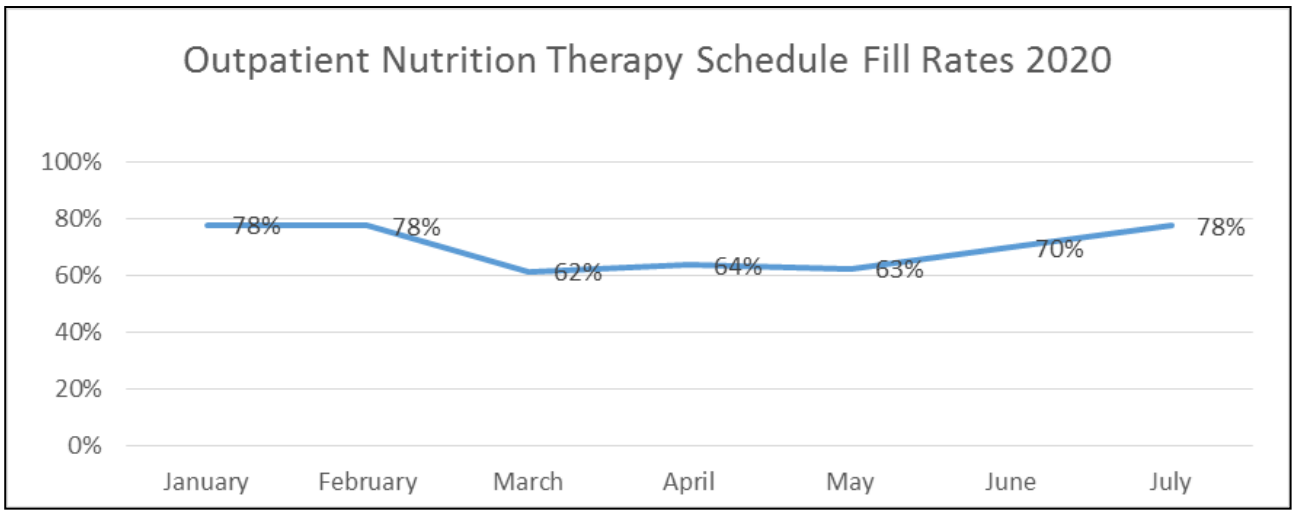

Table 1. Outpatient nutrition therapy schedule fill rates 2020

we were able to provide 265 telehealth visits in March, 1353 in April, and 1092 in May (see Table 2).

In May of 2020, the Cleveland Clinic worked with EPIC©, our electronic health record, and introduced a new platform to complete virtual visits. The new platform involved using Zoom via MyChart©, Cleveland Clinic's secure online health management tool for patients. Our team was quickly trained to use the new program and found it to be much more efficient and easier to work with. The implementation of this platform mid-May allowed us to decrease the number of virtual visits that ended up being phone appointments, as well as those that were provided via Face Time or Google Duo.

Hybrid Remote / In-Person Schedules

The COVID-19 pandemic challenged our ONT team to be adaptable and flexible during a time of significant change. However, change is constant and as everyone was getting into a good rhythm working remotely, we were challenged again to figure out how to get back to face-to-face appointments in clinics across the enterprise. The ONT team started to prepare to return to the clinic in the middle of May. Our goal was to start seeing patients for in-person appointments in a majority of our clinics by June 1, 2020. The first step in this process was each RDN helping to determine their specific clinic's readiness for face-to-face visits. Readiness included adequate office space to allow for a six foot distance between the provider and the patient, and determining how many providers were allowed in the office at one time to ensure there was no crowding in the waiting areas.

The next step was communicating with clinic leadership to determine the best schedule to ensure safety and maintain social distancing. Careful examination and planning led us to establish hybrid schedules that allowed some of the RDNs to see patients in person while others saw patients virtually, or alternating between virtual and in-person appointments throughout the day while on site. This schedule was determined in part by the RDNs' schedule fill rates. For example, while one RDN was working remotely her schedule did not fill, so she was brought back to the clinic to see more patients in person. By mid-November 2020, 11 of 18 RDNs were working one to three days remotely and two to four days on site.

As recommended by our institute, we continue to provide telehealth visits while allowing for in-person appointments for those patients who prefer to come in. Consequently, our schedule fill rates increased to 70% in June and 78% in July (see Table 1), and the number of telehealth visits decreased to 872 and 783 in June and July (see Table 2), respectively. Additionally, in July, five ONT RDNs started the summer session of the Eat Well program in a virtual format for the first time. The groups were limited to six participants in anticipation of some technical difficulties. We found that Eat Well in this format was quite popular and we were able to fill 34 out of 36 spots in the session. Happily, the team has noticed that the classes are going smoothly without any major technical issues and it appears that this format will be successful. We plan to continue to provide Eat Well virtually in the future as well.

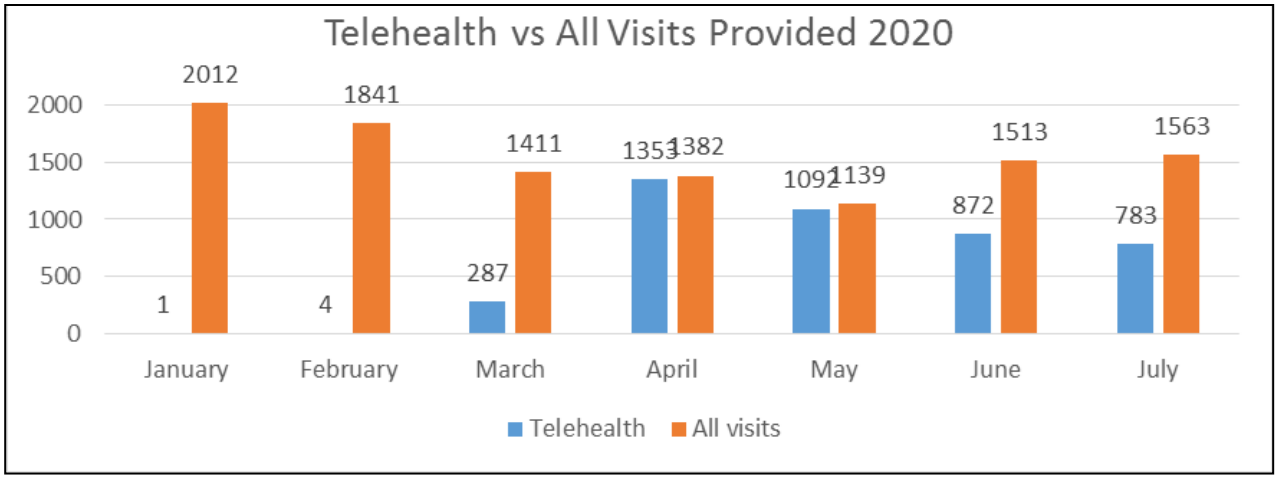

Table 2. Telehealth vs. all visits provided 2020

Conclusion

During this world wide pandemic, when social distancing is necessary, providing health care from a distance is a must. Thanks to great teamwork and flexibility of our group and strong support of the other teams within Cleveland Clinic, we were able to expediently change our practice and shift away from in-person visits while continuing to provide access to MNT to hundreds of patients. Our team finds that telehealth visits provide an effective and safe option for our patients to get the care they need and noted such appointments are more convenient, and patients are therefore more likely to show for their appointments. In the future, we would like to further examine patient retention, follow up and the health outcomes of such visits as compared to those provided in-person. The provision of care via virtual and phone platforms allowed our team to practice MNT in a previously less frequently used manner. Our ability to continue providing such care largely depends on continuing insurance coverage and we are hopeful that insurance companies will make the currently implemented changes permanent.

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CPE Instructions

1. Read the articles titled "Telehealth—Connecting Patients and Providers During the COVID-10 Pandemic Crisis and "MNT Via Telehealth During the COVID-19 Pandemic as Experienced by an Outpatient Nutrition Team".
2. Log on to the CNM DPG website at cnmdpg.org
3. Click on Member Benefits > Professional Development > Self-Study CPEU
4. Take the exam and print your certificate

This article has been approved for 1 CPEU, Level 2, suggested Performance Indicators 5.2, 5.3, 11.1. This CPE is available until Feb 5, 2024. Please note: CDR now requires participants to complete a Critical Thinking Evaluation Tool prior to receiving the CPE certificate. The tool's questions will start immediately following the CPE exam. To submit evaluations or feedback regarding any activities provided by the CNM DPG, please contact QualityCPE@eatright.org.